ADVANCED EYECARE CENTER

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced / Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: ( ) _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type:_____ Solution Used: _____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

What are your visual symptoms (with or without glasses or contacts)? Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

In Example: [2] Eye Strain R L (B) This example indicates a moderate severity in both eyes

[ ] Blurred Vision/Distance	R L B	[ ] Dry Eyes	R L B	[ ] Headaches	R L B
[ ] Blurred Vision/Near	R L B	[ ] Red Eyes	R L B	[ ] Migraine Headaches	R L B
[ ] Double Vision	R L B	[ ] Watery Eyes	R L B	[ ] Loss of Vision	R L B
[ ] Eye Strain	R L B	[ ] Wandering eye	R L B	[ ] Crossed Eyes	R L B
[ ] Eye Infections	R L B	[ ] Mucus Discharge	R L B	[ ] Light Sensitive	R L B
[ ] Eye Pain/Soreness	R L B	[ ] Floaters or Spots	R L B	[ ] Sandy/Gritty Feeling	R L B
[ ] Tired eyes	R L B	[ ] See Flashes	R L B	[ ] Poor Color Vision	R L B
[ ] Burning Eyes	R L B	[ ] See Halos	R L B	[ ] Droopy Lid	R L B
[ ] Itchy Eyes	R L B	[ ] Poor Night Vision	R L B		

Please turn over and complete other side