Welcome to Acuity Eyecare

Name:_____ Date_____ Birthdate ____/____/_____Age:_____
Social Security No:_____ (this is sometimes needed to file your insurance)
Address:_____ City:_____ Zip:_____
Email:_____ Phone (home, cell) (_____)_____
How would you like us to contact you? □ Text □ Email □ Call □ Other: _____
Emergency Contact Name: _____ Emergency Contact Phone Number:(_____)_____
How did you hear about us? □ Google search □ Facebook □ Print Ad □ Referral □ Insurance □ Other: _____

Reason for Today's Visit

Medical Conditions: *please note that the conditions listed below are considered* ***medical*** *problems and are treated using your* ***medical*** *insurance.*

□ Dry Eyes □ Foreign Body Feeling □ Eye pain/soreness □ Red Eyes □ Burning Eyes
□ Flashes/floaters □ Glare/Light sensitivity □ Double Vision □ Swollen Eyelids □ Excess Tearing
□ Itchy Eyes □ Loss of side vision □ Gritty feeling □ Discharge □ Diabetic Eye Exam
□ Stye(s) □ Infection □ Dizziness □ Cloudy Vision □ Eyelid Twitching
□ Previously diagnosed with (circle one): Glaucoma - Cataract - Macular Degeneration – other eye disease
□ Other (please describe): _____

Vision/Wellness: *routine exams of healthy eyes without problems and measurements for new glasses or contacts are billed to your* ***vision*** *plan.*

□ Blurred distance vision □ Blurred near vision □ New glasses □ New contacts

Medical History

Last Eye Exam:_____ Last Medical Exam:_____ Pregnant or Nursing? Yes No
Do you currently, or have you ever had any problems in the following areas? (check all that apply)

Condition	Yes	Treatment or Medication?	Condition	Yes	Treatment or Medication ?
Eyes			Allergies/Hayfever	□	_____
Retinal tear/detachment	□	_____	Sinus Congestion	□	_____
Glaucoma	□	_____	Runny Nose	□	_____
Macular Degeneration	□	_____	Chronic Cough	□	_____
Cataract	□	_____	Dry Throat/Mouth	□	_____
Dry Eyes	□	_____	**Gastrointestinal**		
Eye Allergies	□	_____	Diarrhea	□	_____
Eye Surgery	□	_____	Constipation	□	_____
Eye Injury	□	_____	**Respiratory**		
Amblyopia	□	_____	Asthma	□	_____
Other Eye Conditions:_____			Chronic Bronchitis	□	_____
_____			Emphysema	□	_____
Integumentary (skin)			**Vascular/Cardio**		
Eczema/Rosacea	□	_____	Diabetes/Pre-diabetes	□	_____
Acne	□	_____	High Blood Pressure	□	_____
Dryness	□	_____	Stroke	□	_____
Neurologic			**Bone/Joints/Muscle**		
Headaches	□	_____	Rheumatoid Arthritis	□	_____
Migraines	□	_____	Muscle/joint Pain	□	_____
Seizures	□	_____	Joint Pain	□	_____
Endocrine (thyroid/glands)			**Lymphatic/Hematologic**		
Hypothyroid	□	_____	Anemia	□	_____
Hyperthyroid	□	_____	Bleeding problems	□	_____

Ear, Nose, Mouth, & Throat
Genitourinary: *Please specify type and treatment* _____
Psychiatric: *Please specify type and treatment* _____
Cancer: *Please specify type and treatment* _____

Medications

Do you have any allergies to medications? □ Yes □ No If yes, please list: _____
Do you take any medications: □ Yes □ No If yes, please list (including hormones, oral contraceptives, and non-prescription medications):_____
_____

Social History

Do you use tobacco products? □ Yes □ No
Do you drink alcohol? □ Yes □ No
Do you use illegal drugs? □ Yes □ No
Indicate if you have been exposed to or infected with: □ Gonorrhea □ HIV □ Hepatitis □ Syphilis □ Herpes

Contact Lens/Glasses History

How old are your current glasses? _____ Wearing schedule: □ Part-time □ Full time
Do you wear contacts? Yes / No
What type of contacts do you wear? (circle one) Soft Soft Toric RGP
Brand of contact lens: _____
Brand of cleaning solution: _____
Contact lens prescription: Right eye_____ Left eye _____
Wearing schedule: □ Part-time □ Full time □ Overnight wear
How frequently do you replace your contacts? □ Daily □ Bi-weekly □ Monthly □ I'd rather not say…
Do you want to keep your current brand or are you interested in changing? □ Stay □ Change □ Doctor's choice

Lifestyle & Vision

It's our goal to provide each patient with personalized recommendations and prescriptions to fit their needs – the following information will help us understand your vision needs better.

What is your occupation? _____
Any specific vision requirements for your job? _____
What are your hobbies? _____
Do you use: □ Prescription Sunglasses □ Non-prescription sunglasses □ Safety glasses □ Other_____
What items are <u>most important</u> to you in new glasses?

□ Premium Quality Lenses	□ Anti-glare coating	□ Lightweight
□ Medium Quality Lenses/Value price	□ Polarized lenses	□ Durability
□ Covered by Insurance	□ Thinnest possible lenses	□ Easy to Clean

What are the common problems you have with your CURRENT glasses?

□ Glare	□ Car headlights/night driving	□ Neck/shoulder discomfort at computer
□ Scratches	□ Frame too heavy	□ Bright light
□ Lens fogging	□ Non-glare coating quality	□ Distortion

Family History

Please note any family history (parents, grandparents, siblings, and/or children for the following:

Disease/Condition	Relationship	Disease/Condition	Relationship
Cataract	_____	Diabetes	_____
Glaucoma	_____	Cancer	_____
Crossed Eyes	_____	Heart Disease	_____
Macular Degeneration	_____	Thyroid Disease	_____
Retinal Detachment/Disease	_____	Other	_____