«Last\_Name» «First\_Name» :

Kindly circle or fill in the following information to make your visit run both faster and smoother:

✰marital status: s m d w Husband’s name/if child Father: Wife’s name/if child Mother:

✰Where employed/school ✰Job description (if kid school & grade):

✰ Primary care physician

✰Last eye exam: When and where

✰Have you ever had an eye disease or injury if so what and when

✰Circle if this a Check Up or difficulty with eyes ✰Do you use glasses Y/N ✰General Health: good bad, OK

✰ Get headaches Y/N ✰ Circle if your eyes fatigue or tire @ far/ near/ both ✰Circle if you have blurred vision far/near/ both

✰Do you have glasses if so full time distance only near only ✰Driving: like/don’t like/ ok ✰night driving difficulty Y/N

✰With your glasses is distance vision is good, bad ok, near vision is good bad ok, middle vision is good/bad OK

✰Medication list

✰allergic to medication if so what