VISION CARE

Professional Eyecare. Personalized Eyewear.

Dr. David Holmes **Dr. Heath Holliday**
Dr. Craig Menzies **Dr. Tricia Holliday**

OPTOMETRISTS

Welcome to Our Office

(PLEASE PRINT)

Name _____

Address _____

Phone Number _____ E-mail: _____

Birth Date _____ Age_____ Sex: M ☐ F ☐

Todays Date_____

Last Exam Location _____

Occupation _____

Employer _____

Work Phone_____

Hobbies, Sports, Pastimes _____

Spouse Name _____

Spouse Work Phone _____

Major Purpose of Visit _____

_____

Problems with present glasses or contacts?

_____

Do you or have you ever worn glasses? _____N ☐ Y ☐

When are they used? _____

Do you or have you ever worn contacts? _____N ☐ Y ☐

If yes, what kind? _____ How old?_____

Where are they from? _____

Solutions used? _____

MEDICAL HISTORY

Allergies	N ☐	Y ☐	Arthritis	N ☐	Y ☐
Eye Diseases	N ☐	Y ☐	Cancer	N ☐	Y ☐
Eye Injury	N ☐	Y ☐	Diabetes	N ☐	Y ☐
Eye Surgery	N ☐	Y ☐	Thyroid Disease	N ☐	Y ☐
Lazy Eye	N ☐	Y ☐	Cataracts	N ☐	Y ☐
Glaucoma	N ☐	Y ☐	High Blood Press.	N ☐	Y ☐
Other _____	N ☐	Y ☐	Heart Disease	N ☐	Y ☐

Are you covered by any government assistance program? (Family Health Benefits, Social Services?) _____N ☐ Y ☐

Do you have any Employee Optical Benefits (PVS, Insurance) _____N ☐ Y ☐

If yes what program? _____

NAME OF FAMILY DOCTOR _____

CURRENT MEDICATIONS (Rx or Over the Counter)

		Name of Medication
Antihistamines	N ☐ Y ☐	_____
Diuretics (Water Pill)	N ☐ Y ☐	_____
Blood Press. Pills	N ☐ Y ☐	_____
Sleeping Tablets	N ☐ Y ☐	_____
Oral Contraceptives	N ☐ Y ☐	_____
Eye Drops	N ☐ Y ☐	_____
Diabetic	N ☐ Y ☐	_____
Drug Allergies	N ☐ Y ☐	_____
Other _____	N ☐ Y ☐	_____
_____	N ☐ Y ☐	_____

FAMILY MEDICAL HISTORY

		Relationship
Blindness	N ☐ Y ☐	_____
Cataracts	N ☐ Y ☐	_____
Glaucoma	N ☐ Y ☐	_____
Lazy (Turned) Eye	N ☐ Y ☐	_____
Diabetes	N ☐ Y ☐	_____
Heart Disease	N ☐ Y ☐	_____
High Blood Pressure	N ☐ Y ☐	_____
Macular Degeneration	N ☐ Y ☐	_____
Other _____	N ☐ Y ☐	_____
_____	N ☐ Y ☐	_____

DO YOU . . .

. . use a computer for long periods?	N ☐	Y ☐
. . have more than one pair of glasses?	N ☐	Y ☐
. . always like to wear your glasses?	N ☐	Y ☐
. . spend a lot of time outdoors?	N ☐	Y ☐
. . like to "Change your look" with different styles of eyewear?	N ☐	Y ☐
. . want thinner, lighter lenses?	N ☐	Y ☐
. . have prescription sunglasses?	N ☐	Y ☐
. . have difficulty with reflections or glare particularly at night?	N ☐	Y ☐
. . have difficulty with your bifocals?	N ☐	Y ☐
. . have any interest in contact lenses?	N ☐	Y ☐
. . have any interest in refractive laser surgery?	N ☐	Y ☐

DO YOU EXPERIENCE. . . (X for yes)

☐ Eye pain	☐ Spots	☐ Flashes of light
☐ Itchiness	☐ Soreness	☐ Eye discharge
☐ Eye strain	☐ Dryness	☐ Watery eyes
☐ Red eyes	☐ Burning	☐ Eye infections
☐ Headaches	☐ Dizziness	☐ Vision loss
☐ Blurry distance vision		
☐ Fluctuating vision	☐ Double vision	
☐ Halos around lights	☐ Gritty feeling	
☐ Sensitivity to light	☐ Frequent styes	
☐ Difficulty at night	☐ Glare / reflections	
☐ Trouble reading or learning		
☐ Objects floating in vision		
☐ Uncomfortable glasses or contact lenses		
☐ Other _____		

Thank you for completing this form so thoroughly. It will help us tremendously in assessing your ocular health, comfort and vision and allow us to help you optimize your sight.