Welcome to Eye of the Tiger Vision

Today's Date: _____/_____/_____

Last_____

First_____MI_____

Street_____

City_____State_____Zip_____

Home Phone_____

Cell/Work Phone_____

Email Address_____

Date of Birth_____Age_____ Sex M F
Social Security #

Employer

Any specific issues you wish to address with the Doctor?

If you currently wear glasses:
How old is your current rx, and was it purchased at Pearle Vision?

Are you interested in:
π Glasses?
π Contact Lenses?
π Vision Corrective Surgery?

Do you…..(check box if your answer is yes)
π Work at a computer more than 3 hours a day?
π spend time outdoors? How much?____ hrs./day
π require safety glasses for work or sports?

Date of last Eye Exam:

Insurance Information

Vision Insurance
Subscriber Name
Member ID#
Subscriber Birth Date ____/___/ _____
Subscriber Employer_____
Relationship to Patient

Medical Insurance

Subscriber Name
Subscriber ID#:
Group #
Subscriber Birth Date___/___/ _____
Relationship to Patient

For insurance purposes are you:
π single π married π other

Eye Health History

Please check off if you have ever had or have any of the following:

π Blurry Vision
π Burning
π Cataracts
π Corneal Abrasions
π Crossed Eye/Turn
π Double Vision
π Eye Infections
π Eye Injury
π Flashes of light
π Floaters/Spots
π Glaucoma
π Grittiness
π Headaches
π Iritis/Uveitis
π Eye Pain
π Itchiness
π Color Blindness
π Macular Degeneration
π Dryness
π Retinal Detachment
π Sunlight Sensitivity
π Tearing
π Trouble seeing at night
π Other Eye Disorders

Have you had any major eye infections/surgeries?

Patient Medical History

Name of Family Physician

Town_____ Date of last check up

Current Medications (Rx or OTC)
(List name of medications including eye drops, vitamins, and birth control pills)

_____

Allergies to medications? π Y π N
If yes, which?

Have you had any surgeries in the last five years?
π Y πN
Please List:
_____.

Are you currently pregnant or nursing π Y π N

Do you use cigarettes/tobacco, alcohol, or other substances? πY πN

Have you ever been diagnosed or treated for the following health problems?

πSeasonal Allergies	πArthritis
πHigh Blood Pressure	πMuscular Dystrophy
πHigh Cholesterol	πMultiple Sclerosis
πHeart Disease	πChronic Headaches
πFatigue/Weight Loss	πSeizures
πDiabetes	πDepression
πCrohn's Disease	πADD
πThyroid Disorder	πNeurologic Disorder
πAcid Reflux	πAsthma
π Digestive Disorders	πCOPD
πSTDs/STIs	πCystic Fibrosis
πKidney/Bladder	πLung Disorders
πBlood/Lymph	πSarcoidosis

πCancer _____
(type and location)

For contact lens wearers only:

Do you currently wear contacts? πY πN
What Brand?_____ Rx in lenses: **Right**_____ **Left**_____

How often do you dispose of your lenses?

Do your contacts feel dry? πY πN
Are you interested in Dailies? πY πN
How often do you sleep in your lenses?

Family Medical/Eye History

Please check any that apply to your family and state who the member is:

Blindness	π
Cataracts	π
Corneal Problems	π
Lazy Eye	π
Glaucoma	π
Macular Degeneration	π
Retinal Problems	π
Diabetes	π
Heart Disease	π
High Cholesterol	π