First Name:_____ Middle Initial:_____ Last Name:_____
Address: _____ City:_____
State:_____ Zip:_____ Cell/Home Phone:_____
Date of Birth:_____ Age:_____ Male/ Female:_____
If a minor, parents/guardian name :_____
Email:_____ Occupation:_____

Last Eye Exam:_____ Where:_____
Any concerns with your vision?_____
Have you ever tried contacts:_____ If yes what kind?_____
Are you planning on updating your glasses on this visit?_____
Approximate time per day on a computer screen (smartphone/tablet included): _____
Do you smoke:_____ Alcohol usage if any:_____
Hobbies: _____
Do you wear sunglasses and/or a hat when outdoors?_____

Past or present medical conditions: _____
_____
Current medications:_____
_____ Pregnant or nursing:_____
Allergies to medications: _____ Seasonal allergies:_____
Have you had any eye surgeries?_____

Family medical History: Please Check Box if applies

	Self	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF
Cancer									
Diabetes*									
Hypertension*									
Thyroid									
Cataracts									
Glaucoma*									
Macular Degeneration*									

*Additional scans with the optical coherence tomography scan may be required

How did you hear about us? _____

If there is one thing you think that could make eye care or purchasing contact lens better, what would it be? _____