Reviewed By: _____
Date: _____

EST. 2010 The SPECTACLE Shoppe
PROFESSIONAL EYE EXAMS EXCEPTIONAL EYEWEAR

Print Form

Today's Date / /

PATIENT INFORMATION

Last Name	First Name	MI	Salutation	Date of Birth	Age

Home Address	City	State	Zip

Telephone: - Home: Cell:	E-Mail Address	Social Security Number	Gender	Race

EMERGENCY CONTACT INFORMATION

Emergency Contact	Relationship	Telephone-Primary Telephone-Mobile

MEDICAL INFORMATION

Name of Primary Care Physician	Date of Last Physical	Name of Previous Eye Doctor Date of Last Eye Exam

HEALTH HISTORY

Please circle all that apply to you or any blood relative

☐ **No Known Health Conditions**

(M=mother, F=Father, S=sibling, GP = grandparent)

	You	Family
Allergies	Y N	_____
Autoimmune/Arthritis	Y N	_____
Blood (ie: sickle cell/anemia)	Y N	_____
Breathing Problems	Y N	_____
Cancer	Y N	_____
Cardiovascular	Y N	_____
Cholesterol	Y N	_____
Diabetes	Y N	_____
Gastrointestinal	Y N	_____
Headaches/Migraines	Y N	_____
Herpes Simplex/Zoster	Y N	_____
High Blood Pressure	Y N	_____
HIV/AIDS	Y N	_____
Muscles/Bones/Joints	Y N	_____
Neurological	Y N	_____
Nose, sinus, throat, cough	Y N	_____
Psychiatric, anxiety, depression	Y N	_____
Amblyopia/Lazy Eye	Y N	_____
Blindness	Y N	_____
Cataracts	Y N	_____
Glaucoma	Y N	_____
Macular Degeneration	Y N	_____
Retinal Detachment	Y N	_____
Other Vision Disorder	Y N	_____

DO YOU WEAR GLASSES? Y N

HOW OLD ARE THEY?

DO YOU WEAR CONTACTS? Y N

DO YOU HAVE ANY OF THE FOLLOWING EYE/VISION SYMPTOMS?

- ☐ blurry vision
- ☐ floaters
- ☐ flashes of light
- ☐ eye strain/ headaches
- ☐ double vision
- ☐ eye itching
- ☐ dry eyes
- ☐ eye surgery
- ☐ eye injury

DO YOU USE ANY OF THE FOLLOWING?

- ☐ Tobacco
- ☐ Alcohol
- ☐ Social Drugs

MEDICATIONS

(please list all current)

_____
_____
_____
_____

ALLERGIES

(please list all drug/food)

_____
_____
_____

ARE YOU PREGNANT: Y N

REASON FOR VISIT

(please list any visual/eye problems)

_____

OCCUPATION/HOBBIES