East Avenue VisionCenter

EYE HEALTH/VISION

Which of the following problems are you experiencing with your vision? (check all that apply)

- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Visual discomfort
- ☐ Trouble focusing
- ☐ Double vision
- ☐ Floaters (spots in vision)
- ☐ Flashes of light
- ☐ Other _____

Which of the following problems are you experiencing with your eyes? (check all that apply)

- ☐ Dry
- ☐ Watery
- ☐ Itchy
- ☐ Burning
- ☐ Feels like something in eye
- ☐ Headache
- ☐ Light sensitivity
- ☐ Trouble with glare

Check/answer all that apply:

- ☐ You spend a lot of time on the computer — How long? _____
- ☐ Seasonal allergies — What time of year? _____
- ☐ Sinus problems
- ☐ Wear glasses
  - Are you interested in new glasses? _____
- ☐ Wear contact lenses
  - Are you interested in contact lenses? _____

Family History

Any history of the following ocular conditions? Please list who in your family has/ had these conditions:

Macular Degeneration_____ Glaucoma_____ Cataracts_____

Retinal Detachment_____ Keratoconus_____ Lazy Eye _____

215 East Avenue • Lockport, New York 14094

TEL: (716) 434-2874 • FAX: (716) 434-7890

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Updated Personal and Medical Information

DATE: _____

NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____ CITY _____ STATE _____ZIP _____

HOME PHONE _____ CELL PHONE _____EMAIL _____

OCCUPATION/PLACE OF EMPLOYMENT _____

MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____

FORMER OPTOMETRIST _____ LAST EXAM _____

WHOM MAY WE THANK FOR REFERRING YOU TO THE OFFICE _____

MEDICAL BACKGROUND:

PRIMARY CARE PHYSICIAN _____ LAST PHYSICAL _____

Please list any medical conditions (diabetes, high blood pressure, autoimmune disease, etc.)

_____

_____

Please list all medications (Rx and OTC) – or we can make a copy if you have a list with you

_____

_____

Any known allergies to medications? _____

PEDIATRIC EXAMS:

Are there any academic difficulties? _____ Did child fail a school screening? _____

Grade: _____ School: _____

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