

# WELCOME TO EYE LITE OPTOMETRY

NAME: \_\_\_\_\_ DATE \_\_\_\_\_  
Last First

Date of Birth \_\_\_\_\_

ADDRESS: Street \_\_\_\_\_  
City \_\_\_\_\_ Zip code \_\_\_\_\_

PHONE: day ( ) \_\_\_\_\_ eve ( ) \_\_\_\_\_

PARENT/GUARDIAN (if under 18): \_\_\_\_\_

Social Security Number (for insurance purposes): \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred by: (please circle) friend VSP family another doctor telephone walk-in other

Date of last eye exam: \_\_\_\_\_ Name of doctor \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Name of doctor \_\_\_\_\_

Do you have any medical conditions? \_\_\_\_\_

Do you have any eye conditions? \_\_\_\_\_

Are you currently taking any medications? (Please list the name of the med and what it is) \_\_\_\_\_

Does any family member(s) have the following conditions? Please circle and specify relationship:

Glaucoma:	Yes/No	High cholesterol:	Yes/No
Hypertension:	Yes/No	Cardiovascular disease:	Yes/No
Retinitis Pigmentosa:	Yes/No	Strabismus or lazy eye:	Yes/No
Retinal Detachment:	Yes/No	Cataracts:	Yes/No
Diabetes:	Yes/No		

How old are your current eyeglasses? \_\_\_\_\_

Do you use a computer for 2 or more hours a day? Yes/No

Are your eyes fatigued after using the computer? Yes/No

Do you get headaches often? Yes/No

Do you wear contact lenses? Yes/No

Do you sleep with your contact lenses? Yes/No

If yes, how many nights per week? \_\_\_\_\_

Type of contact lenses: \_\_\_\_\_

How often do you replace them? \_\_\_\_\_

Type of cleaning solution used? \_\_\_\_\_

Do you use an enzyme cleaner? Yes/No How often? \_\_\_\_\_

Please describe the main reason for your visit today.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_