CLARITY VISION OPTOMETRY

Fill Out Completely (Please print)

Last Name _____ First Name _____ Sex □ M □ F

Address _____ City _____ State _____ Zip _____

Phone # _____ □ Home □ Cell □ Work Other # _____ □ Home □ Cell □ Work

Birthdate _____ Occupation _____ Referred By _____

Hobbies (to better assess your visual needs)_____

Primary reason for today's exam: □ annual/routine exam □ contact lens exam □other _____

Last Eye Exam _____ Date of last eye dilation _____ Email Address _____

FOR CONTACT LENS WEARERS ONLY

Current Contact lens brand _____ # of Days worn/week _____ # of Hrs/Day _____

Current Contact lens Solution _____ Replacement schedule □ daily □ 2wks □ 1 mth □ other _____

Do you sleep wearing your contact lenses? _____ if yes, # of days/weeks _____

MEDICAL HISTORY

Gastrointestinal □ No Problem □ Ulcer □ Colitis □ Heartburn □ Diarrhea □ Other _____	Neurological □ No Problem □ Epilepsy □ Multiple Sclerosis □ Headaches □ Numbness □ Other _____
Ear/Noise/Throat □ No Problem □ Ulcer Respiratory Infection □ Sinusitis □ Chronic Colds □ Other _____	Cardiovascular □ No Problem □ High Blood Pressure □ Heart Disease □Vascular Disease □ Stroke □ Chest Pain □ Irregular Heart Beat □ Other _____
Musculoskeletal □ No Problem □ Muscular Dystrophy □ Osteoarthritis □ Joint Pain □ Muscle Aches □ Other _____	Respiratory □ No Problem □ Asthma □ Bronchitis □ Emphysema □ Wheezing □ Coughing □ Other _____
Integumentary (Skin) □ No Problem □ Psoriasis □ Eczema □ Rashes □ Acne □ Excessive Dryness □ Other _____	Allergic/Immune □ No Problem □ Allergies _____ □ Rheumatoid Arthritis □ Drug Allergies _____□ Lupus □ HIV □ Other _____
Endocrine □ No Problem □ Thyroid Dysfunction □ Hormonal Dysfunction □ Type 1 Diabetes □ Type 2 Diabetes □ Other _____ Blood/Lymph □ No Problem □ Anemia □ Leukemia □ Other _____	Psychiatric □ No Problem □ Depression □ Bipolar □ADD/ADHD □ Other _____ Genitourinary □ No Problem □ STD □ Bladder Infection □ Blood in Urine □ Other _____

Check any that applies to yourself or an immediate family member.

	Myself	Family Member(s) – please list relation	Myself	Family member(s)
Glaucoma	□	□ _____	Lazy Eye □	□ _____
Macular Degeneration	□	□ _____	Retinal Detachment □	□ _____

Did your last eye doctor mention any eye condition(s) that needs to be monitored? _____

If female, are you pregnant? □ No □ Yes

Have you had any eye surgery (including lasik)? If yes, please list: _____

Are you currently taking any medications (including over the counter and eye drops)? If Yes, please list:

_____

I authorize the release of any medical or other information necessary to process this claim (if using my insurance)

Patient Signature: _____ Date: _____