WELCOME TO LEXINGTON EYE CARE!

Please assist us in our effort to serve you better by filling out this brief questionnaire. It gives us valuable information about your vision, and is required by your insurance company!

Name (Last, First, MI) _____

Address _____City_____State_____Zip_____

Telephone (Home) _____ Cell Phone _____

Date of Birth _____ Age_____ SSN _____-_____-_____

Employer _____ Gender: M F

How did you hear about us? _____

Email _____

Spouse Name (Parent if patient is minor) _____

Address (If different from above) _____

Spouse/Parent SSN_____-_____-_____ DOB _____ Telephone _____

Insurance Company _____Policy # _____

Policy Holder _____ SSN _____-_____-_____

Policy Holder DOB _____ Work Related Injury? Y / N Date of Injury _____

Are You Experiencing Any of the Following Ocular Symptoms?

☐ Floaters	☐ Flashes	☐ Blurry Side Vision	☐ Blurry Central Vision
☐ Red Eyes	☐ Itching	☐ Burning	☐ Tearing
☐ Dryness	☐ Pain	☐ Light Sensitivity	☐ Problems Reading

Do You Have Any Problems With the Following?

☐ Ear Nose Throat	☐ Skin	☐ Hematologic/Blood	☐ Glands
☐ Neurological	☐ Cardiovascular	☐ Genitourinary	☐ Diabetes
☐ Musculoskeletal	☐ Allergies/Hay Fever	☐ Immunologic	☐ Lung/Asthma
☐ Breast/Uterine/Cervical	☐ Stomach/Bowel	☐ High Cholesterol	☐ Liver/Pancreas
☐ HIV Exposure/AIDS	☐ Convulsions/Seizures	☐ Cancer (Type)	☐ Back Problems

Please explain above:_____

_____

Do you smoke? _____ # Packs/ Day _____ Are you Presently Pregnant or Breastfeeding? ___
Do You Drink Alcoholic Beverages? _____ How Often _____ IV or Recreational Drug Use? ___

Please Check all that Apply

	Self	*Family*		*Self*	*Family*
Glaucoma	☐	☐	Hypertension	☐	☐
Cataract	☐	☐	Heart Disease	☐	☐
Macular Degeneration	☐	☐	Previous Eye Injury	☐	☐
Retinal Detachment	☐	☐	Thyroid Eye Disease	☐	☐
Blindness	☐	☐	Nearsighted	☐	☐
Diabetic Eye Disease	☐	☐	Farsighted	☐	☐
Lazy Eyes	☐	☐	Previous Eye Surgery	☐	☐
Optic Nerve Disease	☐	☐	Blepharitis	☐	☐
Comments:			Drooping Eyelids	☐	☐
			History of Stroke	☐	☐

Surgical history: _____

_____

Please Answer All That Apply to You:

Current Medication:

_____
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Allergies:

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Current Primary Care Physician:

_____

Are You Interested in the Following?

☐ Contact Lenses
☐ Tinted Contact Lenses
☐ Bifocal Contact Lenses
☐ Extended Wear Contacts
☐ Laser Vision Correction
☐ Prescription Sunglasses
☐ Protective Eyewear
☐ Corneal Refractive Therapy (Non-Surgical Vision Correction)

If You Wear Contact Lenses, Do You Experience Any of the Following Problems?

☐ Distance Blur
☐ Redness
☐ Handling Difficulties
☐ Near Blur
☐ Irritation
☐ Itching
☐ Tearing
☐ Dryness
☐ Maintenance Problems

How Often Do You Replace Your Contact Lenses?
☐ Daily ☐ Two Weeks ☐ Monthly ☐ Quarterly ☐ Yearly

How Often Do You Remove Your Contact Lenses?
☐ Daily (i.e. not sleeping in lenses) ☐ Every Few Days ☐ Only When Eyes are Irritated

Are You Happy With Your Present Contact Lenses? ☐ Yes ☐ No

_____ _____
Patient/Parent Signature **Date**