

Christiana Eyecare LLC Photo ID? ☐ Today's Date _____ Pt. ID# _____

People you Know. People Who Care.

WELCOME TO OUR OFFICE



Name _____ Date of Birth _____
FIRST LAST MI (Circle)

Street _____ City _____ State _____ Zip _____

Primary Phone _____ Alternate Phone _____ E-mail Address _____
h w c h w c

Spouse (or Parent's Name) _____ Occupation (Or School) _____

How will you settle your account today? Check ☐ Cash ☐ Credit Card ☐

How did you first here about our office? Referred by (Name): _____ Please Circle: Online Newspaper Other:

We do not participate with any vision plans _____

(Please initial your acknowledgment)

What is the major purpose of this visit? _____ *If Any-What sports do you participate in? _____

How many hours per day do you spend on an electronic device? (computer, phone, tablet, ect.) _____

Do you wear sunglasses? Yes No Are you interested in contact lenses? Yes No

Have you ever worn/are you currently wearing contacts? No Yes – What kind? _____ Solutions used _____

Name of Physician _____ Are you currently under the care of a Physician? Yes No

Please indicate if you are pregnant _____

MEDICAL HISTORY

Allergies	Yes	No	Eye Surgery	Yes	No
Arthritis	Yes	No	Kidney	Yes	No
Asthma	Yes	No	Cataracts	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No
Skin Disorder	Yes	No	Diabetes	Yes	No
Nerves	Yes	No	Date diagnosed	_____	
Eye Disease	Yes	No	Type 1 2	_____	
Heart Disease	Yes	No	How Controlled?	_____	
High Blood			Insulin, Oral, Diet	_____	
Pressure	Yes	No		_____	
Eye Injury	Yes	No	A1C	_____	
			Is it under control?	_____	
Lazy Eye	Yes	No	Yes No	_____	
Other	_____				

FAMILY MEDICAL HISTORY

			Relationship
Blindness	Yes	No	_____
Cataracts	Yes	No	_____
Glaucoma	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Other	Yes	No	_____

Do you experience...

(Vision Symptoms)

___ Blurry Near Vision	___ Blurry Distance Vision
(Reading)	(Driving, TV)
___ Eye Strain	___ Uncomfortable Glasses
___ Fatigue	___ Uncomfortable Contact
___ Trouble working up close	Lenses
___ Other	_____

(Medical Symptoms)

___ Watery eyes	___ Burning
___ Sensitive to light	___ Glare or Reflection
___ Headache	___ Gritty Feeling in eyes
___ Objects Floating in Vision	___ Spots
___ Itchiness	___ Sudden loss of vision
___ Flashes of light	___ Jaw pain
___ Dryness	___ Double Vision

CURRENT MEDICATIONS AND SUPPLEMENTS

ALLERGIES Medical or Environmental

