

# Advanced Eyecare

For a Lifetime of Healthy Vision

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## WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer (or School) \_\_\_\_\_  
Occupation (or Grade) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F \_\_\_\_\_  
E-Mail \_\_\_\_\_  
What is your Marital Status? M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

### MEDICAL HISTORY

Allergies  No  Yes Arthritis  No  Yes  
Asthma  No  Yes Cancer  No  Yes  
Skin Disorder  No  Yes Diabetes  No  Yes  
Eye Diseases  No  Yes Heart Disease  No  Yes  
Eye Injury  No  Yes High Blood Pres  No  Yes  
Eye Surgery  No  Yes Kidney  No  Yes  
Lazy Eye  No  Yes Nerve Problems  No  Yes  
Cataracts  No  Yes Other  No  Yes  
Glaucoma  No  Yes \_\_\_\_\_

### CURRENT MEDICATIONS

Please list all of your medications

(Including non-prescription medications, vitamins, and supplements.)

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

Who is your physician? \_\_\_\_\_

### FAMILY MEDICAL HISTORY

RELATIONSHIP

Macular Degeneration  No  Yes \_\_\_\_\_  
Cataracts  No  Yes \_\_\_\_\_  
Glaucoma  No  Yes \_\_\_\_\_  
Diabetes  No  Yes \_\_\_\_\_  
Heart Disease  No  Yes \_\_\_\_\_

Date of Last Exam \_\_\_\_\_ Date \_\_\_\_\_

What specific problems are you having with your eyes, vision, glasses, and /or contact lenses?  
\_\_\_\_\_  
\_\_\_\_\_

Spouse (or Parent) Name \_\_\_\_\_

Spouse (or Parent) Work Phone \_\_\_\_\_

Vision Insurance \_\_\_\_\_

Do you have a flexible spending account or cafeteria plan at your work?  Yes  No

How will you settle your account today?

Check  Cash  Credit/Debit Card

### Do you . . .

..Have a spare pair of glasses?  Yes  No  
..Have prescription sunglasses?  Yes  No  
..Have problems with glare or reflections from your glasses? (particularly when driving at night)  Yes  No  
..Want information on thinner/lighter lenses?  Yes  No  
..Spend a lot of time outdoors?  Yes  No  
..Wear lined bifocals or trifocals?  Yes  No  
..If yes, are you interested in trying progressive/ no line lenses?  Yes  No  
..Have family members in need of eye care?  Yes  No

**Have you ever worn / are you currently wearing contacts?**  Yes  No

What kind? \_\_\_\_\_ Solutions used \_\_\_\_\_

**Are you interested in . . .**

..Contact Lenses?  Yes  No  
..Refractive Surgery?  Yes  No

### Do you experience . . .

Blurry distance vision  Burning  
 Blurry near vision  Itching  
 Trouble seeing at night  Watering  
 Reading problems  Dryness  
 Sensitivity to light  Redness  
 Glare or reflections  Sudden loss of vision  
 Uncomfortable glasses  Objects floating in vision  
 Uncomfortable contact lenses  Light Flashes  
 Gritty feeling in eyes  Eyestrain  
 Headaches  Double Vision  
 Other: \_\_\_\_\_

**How did you first hear about our office?**

Friend or Relative. Who? \_\_\_\_\_  
 Another Health Care Provider. Who? \_\_\_\_\_  
 Yellow Pages. Which Directory? \_\_\_\_\_  
 Print Advertisement. \_\_\_\_\_  
 Radio / TV. Which station? \_\_\_\_\_  
 Previous Patient. Who? \_\_\_\_\_  
 Other \_\_\_\_\_