EYES OF WESTWOOD OPTOMETRY
WELCOME TO OUR OFFICE

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information.

❍ Mr. ❍Miss ❍ Mrs. ❍ Ms. ❍Dr. ❍ Male ❍ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______ Date of Birth ______ Home Phone ______ Cell Phone ______

Email Address ______ Person Responsible for Account ______

How were you referred to our office?
❍ Insurance Listing ❍Web Site ❍ Internet ❍ Advertisement ❍Patient/Friend____________________________

PRIMARYVISION INSURANCE INFORMATION

Name of Primary Vision Insurance Company ______

Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number or SS# ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured:
❍ Self ❍ Spouse ❍ Child ❍ Other

Employment status:
❍ Full-time Student ❍ Part-time Student ❍ Employed

HEALTH HISTORY

Past Illnesses or Injuries: ____

Past Surgeries: ____

Past Eye Surgeries or Eye Injuries: ____

Current Medications: ____

Current Eye Drops: ____

Medications that cause reactions or sensitivities: ____

Specific Allergies: ____

PERSONAL EYE HISTORY

Glaucoma	❍Yes ❍No	Eye Injuries	❍Yes ❍No	Eye Surgery	❍Yes ❍No
Cataracts	❍Yes ❍No	Blurred Vision Distance	❍Yes ❍No	Floaters or Spots	❍Yes ❍No
Macular Degeneration	❍Yes ❍No	Blurred Near Vision	❍Yes ❍No	Redness	❍Yes ❍No
Retinal Detachment	❍Yes ❍No	Amblyopia (Lazy Eye)	❍Yes ❍No	Burning or itching	❍Yes ❍No
Sandy or Gritty Feeling	❍Yes ❍No	Dryness	❍Yes ❍No		
Infection of Eye or Lid	❍Yes ❍No	Tired Eyes	❍Yes ❍No		

GENERAL HEALTH CONDITION

Diabetes	❍Yes ❍No	Hypertension	❍Yes ❍No	High Blood Pressure	❍Yes ❍No
Arthritis	❍Yes ❍No	Thyroid Disease	❍Yes ❍No	High Cholesterol	❍Yes ❍No

FAMILY HISTORY

Glaucoma	❍Yes ❍No	Cataracts	❍Yes ❍No	High Blood Pressure	❍Yes ❍No
Diabetes	❍Yes ❍No	Blindness	❍Yes ❍No		
Retinal Detachment	❍Yes ❍No	Macular Degeneration	❍Yes ❍No		

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Welcome To Our Office

SPECTACLE LENS HISTORY

Do you currently wear glasses? ❍Yes ❍No
Are your glasses your current prescription? ❍Yes ❍No
Type of glasses: ❍Full Time ❍Part Time ❍Distance ❍Close
Glasses Owned: ❍Single Vision ❍Progressive ❍Bifocals ❍Backup ❍Safety ❍Sports
Have you had trouble in the past with glasses? ❍Yes ❍No
Do you wear sunglasses? ❍Yes ❍No Are your sunglasses your current prescription? ❍Yes ❍No
Do you drive? ❍Yes ❍No Do you have any visual difficulty while driving? ❍Yes ❍No
Do you use a computer? ❍Yes ❍No How many hours/day? _______________
Do your eyes feel strained while using the computer? ❍Yes ❍No
Do you have glare problems? ❍Yes ❍No
Are you planning on getting new glasses today? ❍Yes ❍No

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CONTACT LENS HISTORY

Do you currently wear contact lenses? ❍Yes ❍No
Have you ever tried to wear contact lenses? ❍Yes ❍No
Reason for stopping?____
Do your contacts become less comfortable as the day goes on? ❍Yes ❍No
Do your eyes sometimes get red or feel irritated with your contacts? ❍Yes ❍No
Would you like to sleep or nap in you contacts? ❍Yes ❍No
Do you have an interest in trying new advanced contact lenses? ❍Yes ❍No
What Solutions do you use? ___________________________________

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Do you have questions about or interest in laser refractive surgery (LASIK)? ❍Yes ❍No
Reason for today's visit?____
When was your last eye examination?____
Your occupation____
Do you participate in any sports? ❍Yes ❍No If so what?__________________________________
Hobbies____
Do you have any other comments or questions?_____________________________________

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