PATIENT PROFILE (Please print)

NAME:	BIRTHDATE:	OCCUPATION:
LAST EYE EXAM:	LOCATION OF LAST EXAM:	
REASON FOR TODAY'S VISIT:		

DO YOU PRESENTLY WEAR EYEGLASSES?	YES ☐	NO ☐	HAVE YOU EVER WORN CONTACT LENSES?	YES ☐	NO ☐
DO YOU WEAR CONTACT LENSES NOW?	YES ☐	NO ☐	IF NO, ARE YOU INTERESTED IN TRYING CONTACT LENSES?	YES ☐	NO ☐ MAYBE ☐

What type of work do you do? _____

Do you have any hobbies? _____

Are you active in sports? _____

Do you work on a computer? If so, how many hours per day? _____

Do you ever see double? _____

Do you have frequent headaches? _____

Are you sensitive to light? _____

Are you having any problems with your present eyeglasses or contact lenses? If so, please explain: _____

_____

Do **you** or **any family member** have DIABETES? Who? _____ ☐Y ☐N

Do **you** or **any family member** have GLAUCOMA? Who? _____ ☐Y ☐N

Do **you** or **any family member** have CATARACTS? Who? _____ ☐Y ☐N

Does **anyone in your family** have any EYE DISEASE? Who? _____ ☐Y ☐N

Have **you** ever had any **eye disease, injury, or surgery**? Describe: _____ ☐Y ☐N

Do you have any allergies? List: _____ ☐Y ☐N

_____

Do you have any medical problems? Describe: _____ ☐Y ☐N

_____

Do you take any medications? List: _____ ☐Y ☐N

_____

If you are a CURRENT contact lens wearer, please answer the following questions:

What type of contacts lenses do you wear? ☐Soft ☐Rigid

What brand of contact lenses do you wear? _____

What are the powers of your contact lenses (if you know)? _____

How many hours per day do you wear your contact lenses (on average)? _____

How often do you replace your contact lenses? ☐daily ☐weekly ☐2 weeks ☐monthly ☐every ____ months

What solutions do you use to care for your contact lenses? _____

Are you able to wear your contact lenses all day with good **comfort** and **vision**? If not, what problems are you experiencing? _____