Guardian: Date: Tuesday 10:00 JP

Name:

Address:

City, St: Zip:

Phone(H): W: C:

Sex:

Date of Birth:

E-Mail:

Occupation:

Notify me by: ☐ Text ☐ Phone ☐ Emai ☐ Mail

Who may we thank for referring you to our office?

☐ Friend ☐ Insuranc ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

Approx. Date of Last Eye Exam:

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at Near
- ☐ Blur at Far & Near
- ☐ Itching
- ☐ Burning
- ☐ Redness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Flashes/Floaters
- ☐ Loss of vision
- ☐ Double vision
- ☐ Sandy/Gritty
- ☐ Spots or shadows
- ☐ Diabetes eye
- ☐ Medical eye
- ☐ Other...

Which Eye? ☐ Right eye ☐ Left ☐ Both eyes

How long has it bothered you?

- ☐ Started today
- ☐ 1-2 days
- ☐ 3-7 days
- ☐ 1-2 weeks
- ☐ 2-4 weeks
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ Over 6 months

Severity? ☐ Mild ☐ Moderat ☐ Sever

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right

Left

Contacts: Right

Left

Medical Doctor(s):

Spectrum Optical

1257 Pineview Drive
Morgantown WV, 26505
304-599-7034
Fax-
E-mail: spectrumoptical@comcast.net
http://www.spectrumoptical.com

Please note that insurance does NOT cover the Contact Lens Fitting Evaluation

Vision or Primary Insurance

Ins. Name:

Ins Number:

Relationship:

Insured:

Insured DOB: Ins. Sex: ○ M ○ F

Co-pay: Materials: ○ Y ○ N

Medical or Secondary Insurance

Ins. Name:

Ins Number:

Relationship:

Insured:

Insured DOB: Ins. Sex: ○ M ○ F

Co-pay: Materials: ○ Y ○ N

Participate in a flex spending account? ☐ Y ☐ N

Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Never Smoked
- ☐ Former Smoker
- ☐ Smoker
- ☐ Other...

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Lazy Eye
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ Thyroid
- ☐ Other...

Current Medicines — Amount

NONE

Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

Mark box if yes.

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of your contact lenses?
- ☐ Would prefer colored contacts?
- ☐ Do the lines and head tilting bother you with bifocals?

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ None
- ☐ Other...

Allergies

- ☒ None
- ☐ Penicillin
- ☐ Sulf
- ☐ Eye drops
- ☐ Other...

Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction
- ☐ Have more than 1 pair of current Rx

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** Your information is protected by our privacy policy.

I have received a copy of Spectrum Optical "Notice of Privacy Practices". " Let me know ahead of time if I have to pay extra".

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____

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