RealEyes 575-758-3215

Guardian: _____ **Date:** 11/6/15

Name: _____ _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ **(C):** _____

Date of Birth: _____ **Sex:** ____

Vision or Primary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

Medical or Secondary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

E-Mail: _____

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

Referred by (name of friend we can thank)

☐ Friend ☐ Relative ☐ Phone Book ☐ Other...

Medical Doctor(s):

Approx. Date of Last Eye Exam:

Allergies

☐ None
☐ Penicillin
☐ Sulfa
☐ Other...

Current Medicines

Race **Ethnicity** **Language**

History or Problems

☐ Allergy	☐ Eye Injury	☐ Migraine
☐ Arthritis	☐ Glaucoma	☐ MS
☐ Asthma	☐ Heart disease	☐ Respiratory
☐ Blood Pressure	☐ High Cholesterol	☐ Stye
☐ Cataract	☐ Keratoconus	☐ Thyroid
☐ Crossed Eyes	☐ Kidney	☐ Other...
☐ Diabetes	☐ Lasik	
☐ Droopy Lid	☐ Lazy Eye	
☐ Ear Problems	☐ Macular Degen.	
☐ Eye Infection	☐ Melanoma	

Clear

Eye wear History (have you ever worn...)

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

Family History (parents, grandparents, siblings)

☐ Blindness	☐ Kidney	☐ Thyroid
☐ Cancer	☐ Macular Degen.	☐ Glaucoma
☐ Crossed Eyes	☐ Retina Detach	☐ None
☐ Color Blind	☐ Heart Disease	☐ Other...
☐ Diabetes	☐ Blood Pressure	

Social History

☐ Computer	☐ Skiing	☐ Swim	☐ Other...
☐ Reading	☐ Golf	☐ Bike	
☐ Student	☐ Fishing	☐ Drug Use	
☐ Music	☐ Tennis	☐ Alcohol Use	

Occupation

Clear

Smoking

◯ Current everyday	◯ E cigarette
◯ Current some day smoker	◯ Never
◯ Former smoker	

Current eye problem(s) (please circle the "main" problem)

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

☐ Right eye ☐ Left ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

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

☐ Getting better ☐ Getting worse ☐ About the same

Are you interested in contact lenses information?

Clear

☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient _____

Printed: 11/6/15 DOB: