Date: 11/6/15

Name:

Address:

City, St: **Zip:**

Phone(H): W: C:

Date of Birth: **Sex:**

E-Mail:

Occupation:

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

Who may we thank for referring you to our office?

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

Name:

Emergency Contact Name and Phone:

Approx. Date of Last Eye Exam:

RealEyes

1353 C Paseo Del Pueblo Sur
Taos NM, 87571
(575) 758-3215
Fax- (575) 751-9280
E-mail: generalinfo@realeyestaos.com
http://www.realeyestaos.com

Race
- ○ White
- ○ Black/African
- ○ Asian
- ○ Native Hawaiian or Other Pacific

Ethnicity
- ○ Not Hispanic or Latino 2186-5
- ○ Hispanic or Latino 2135-2

Language ☐ English ☐ Other... ☐ Spanish

Smoking
- ○ Current everyday
- ○ Current some day smoker
- ○ Former smoker
- ○ E cigarette
- ○ Never

What is the major purpose of this visit:

- ☐ Blur at Far
- ☐ Blur at 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

Symptoms?

☐ Getting better ☐ Getting worse ☐ About the same

Primary Care Doctor:

Specialist (if any):

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

Past Medical History

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

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?

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulf
- ☐ Other...

Social History

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

Current Medicines | Dose

Current Medicines	Dose

Family History

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

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____

Print Name: _____

Printed: 11/6/15