Welcome to Riverbend Eyecare. In order to provide you with the best care we ask that you please complete this form.

Name: _____ Date: _____

Who is your primary medical doctor (PCP): _____

Eye History

Do you experience any of the following problems or conditions?

	No	Yes
Reduced Vision	[ ]	[ ]
Double Vision	[ ]	[ ]
Eye Pain or Irritation	[ ]	[ ]
Glare/Light Sensitivity	[ ]	[ ]
Dry Eyes	[ ]	[ ]
Red Eyes	[ ]	[ ]
Floaters	[ ]	[ ]
Flashes of Light	[ ]	[ ]
Cataracts	[ ]	[ ]
Glaucoma	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Lazy/Crossed Eye	[ ]	[ ]

Contact Lenses

	No	Yes
Do you currently wear contact lenses?	[ ]	[ ]
If Yes: Extended/Overnight Wear?	[ ]	[ ]

Average wear time per day: _____

Solution System used: _____

Please list any complaints/concerns with current lenses: _____

_____

	No	Yes
If No: Are you interested in being fit for contact lenses?	[ ]	[ ]

Other Eye Concern/Interest:_____

Medical History

Do you experience any of the following problems or conditions?

	No	Yes
Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
High Cholesterol	[ ]	[ ]
Thyroid Disease	[ ]	[ ]
Sinus Disease	[ ]	[ ]
Allergies/Hayfever	[ ]	[ ]
Arthritis	[ ]	[ ]
Shingles/Herpes Zoster	[ ]	[ ]
Headaches	[ ]	[ ]
Shortness of Breath	[ ]	[ ]
Weight Loss/Gain	[ ]	[ ]
Excessive Thirst/Urination	[ ]	[ ]
Prednisone (Steroid) use	[ ]	[ ]
Easy Bleeding/Bruising	[ ]	[ ]
Dizziness/Vertigo	[ ]	[ ]
Cancer:_____	[ ]	[ ]

Family History

Do any of your *direct/blood relatives* have any of the following conditions?

	No	Yes
Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Blindness	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Glaucoma	[ ]	[ ]
Lazy/Crossed Eye	[ ]	[ ]

Social History

	No	Yes
Do you smoke tobacco?	[ ]	[ ]
Do you drink alcohol?	[ ]	[ ]

Average number of servings of fruits & vegetables eaten per day:_____

Occupation:_____

Computer Use (hours/day):_____

Hobbies:_____

_____

Medications/Vitamins	**Drug Allergies**	**Eye Surgeries**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dr. Reviewed & Date: