cityeyeworks

Name: ____________________________ Date of Birth_________

Address: ____

Phone: ___________________ Email:

Preferred method of communication:

Emergency contact (name/number/relationship):

Welcome to City Eyeworks!

How did you hear about our office?

What is the main reason for today's exam:

When was your last eye exam?

Do you currently wear contact lenses or glasses?

Yes, I wear them for (distance, near, full-time):

No, I don't but I am interested in:

Have you been treated for previous ocular infections, injuries or surgeries? (Please list)

Health history:

Last health exam: **Primary care doctor/clinic:**

Medications:

Medication allergies: Other allergies:

Have you or an immediate family member been diagnosed with any of the following conditions:

Diabetes

Hypertension

Elevated cholesterol

Thyroid condition

Arthritis

Additional health conditions or concerns:

Are you pregnant or nursing:

Ocular history:

Have you or an immediate family member been diagnosed with the following

Cataracts

Retinal Detachment

Glaucoma

Amblyopia (lazy eye)/
Strabismus (eye turn)

Macular Degeneration

Color deficiency:

Other: