

Welcome to 20/20 Visions, LLC

Today's Date: _____ Date of Birth: _____ Age: _____ SS# _____

Name: _____ Sex M F Other Family Members: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ e-mail: _____

Billing: Please indicate responsible party for payment _____

Work Phone: _____

Employer (or School): _____

Occupation (or grade): _____

What is the primary reason for your visit today? _____

Are you here for a work related injury? Y N If so, name of employer to bill? _____

Do you wear glasses? Y N For Reading? Y N For Distance? Y N

Do you wear contacts? Y N Type of contacts? _____

Are you interested in contact lenses? Y N

How old are your glasses or contacts? _____ Are you interested in refractive surgery? Y N

When was your last eye exam? _____

Are there any problem with your glasses or contacts? Y N If so, please describe: _____

Who referred you to 20/20 Visions, or how did you find out about us? _____

Please indicate if you or any immediate family members have any of following conditions. Please note relationship of family member. (i.e. father, grandmother, sister)

Name of Medication _____ Name of Physician: _____

	You	Relative	Relationship	Name of Medication RX or over the counter
Eye Injury	_____	_____	_____	_____
Eye surgery	_____	_____	_____	_____
Lazy eye	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Cataracts	_____	_____	_____	_____
Mac. Degeneration	_____	_____	_____	_____
Allergies	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____
High blood press.	_____	_____	_____	_____
Kidney problems	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Skin Disorders	_____	_____	_____	_____

Please list any other health conditions: _____

Do you experience....

- Burning Redness
- Itchiness Double vision
- Watery eyes Eye strain
- Dry eyes Soreness
- Headaches Blurred vision
- Light sensitivity Nausea
- Flashes of light Spots/Floaters
- Fainting or Dizziness
- Gritty feeling in eyes
- Other _____

Do you...

- Work at a computer for long periods of time? Y N
- Have prescription sunglasses? Y N
- Have more than one pair of glasses? Y N
- Want info on thinner lighter lenses? Y N
- Always wear your glasses? Y N
- Have any family members in need of eye care? Y N
- Spend time outdoors? (how much!) Hrs per week _____
- Have a problem with glare or reflection from a computer or when driving at night? Y N

Please have your insurance cards ready for us to photocopy. Also, please sign the back of this form if you do have insurance. Thank you for choosing us for your eye care needs!