WELCOME TO ROCKRIMMON VISION SOURCE

Name:		Nickname:
Today's Date:	Age:	Date of Birth:
Approx date of last eye exam:	Name of previous eye doctor or clinic:	
Occupation:	Number of hours on computer per day:	
Hobbies/Sports:		
What is the reason for today's visit? What visual/ocular problems are you having? ☐Routine only, no problems.		
Any current or past medical conditions that we should be aware of?		
Females, are you pregnant and/or nursing? No Yes		
What medications are you taking?		
What are you allergic to (including medications)?		
Have you ever had any eye injuries or surgeries? What/when?		
If the doctor finds that you are a good candidate for refractive surgery, would you perhaps be interested?		

I AM CURRENTLY HAVING PROBLEMS WITH: (PLEASE CHECK APPROPRIATE BOXES BELOW)

	Blurred vision at distance		Eye strain
	Blurred vision at near		Itchy eyes
	Dry eyes		Watery eyes
	Headaches (often or severe)		Floaters/Flashes of light

Other:

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE OR HAVE HAD ANY OF THE FOLLOWING?

		Who? Self/Family	
Glaucoma	Y N		Comments
Cataracts	Y N		
Macular Degeneration	Y N		
Diabetes	Y N		
Seasonal allergies	Y N		Does it affect your eyes?
Multiple Sclerosis	Y N		
Thyroid conditions	Y N		
Lazy eye/crossed eye	Y N		
Heart problems	Y N		
Blindness	Y N		
High blood pressure	Y N		

Other:

CONTACT LENS WEARERS ONLY:

What type of contacts do you wear?
How old are your current contacts?
How many hours a day do you wear contacts?
Do you ever sleep in your lenses? How often?
How often do you replace your lenses?
What solutions do you use?