Guardian: _____

Name: _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ W: _____ C: _____

Date of Birth: _____ **Sex:** _____

E-Mail: _____

Occupation: _____

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

Who may we thank for referring you to our office?

☐ Friend ☐ Insuranc ☐ Phone Book ☐ Other...

Emergency Contact Name and Phone:

_____

Approx. Date of Last Eye Exam: _____

What is the major purpose of this visit:

☐ Blur at Far
☐ Blur at Near
☐ Blur at Far & 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 weeks ☐ 3-6 months
☐ 1-2 days ☐ 2-4 weeks ☐ Over 6 months
☐ 3-7 days ☐ 1-3 months

Severity? ☐ Mild ☐ Moderat ☐ Sever

Getting Worse?

☐ Getting better ☐ Getting worse ☐ About the same

Current Prescription:

Glasses: Right _____

Left _____

Contacts: Right _____

Left _____

Medical Doctor(s):

Spectrum Optical

1257 Pineview Drive
Morgantown WV, 26505
304-599-7034
Fax- 304-599-5483
E-mail: spectrumoptical@comcast.net
http://www.spectrumoptical.com

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

Social History

☐ Computer
☐ Reading
☐ Student
☐ Music
☐ Skiing
☐ Golf
☐ Fishing
☐ Tennis
☐ Swim
☐ Bike
☐ Drug Abuse
☐ Alcohol Abuse
☐ No alcohol or drug abuse
☐ Never Smoked
☐ Former Smoker
☐ Smoker
☐ Other...

Race

Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear Problem
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Heart
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Lazy Eye
- ☐ Macular Degen.
- ☐ Migraine
- ☐ MS
- ☐ Psychological
- ☐ Sinus
- ☐ 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
- ☐ Eye drops
- ☐ Other...

Current Medicines

Current Medicines	Amount

Family History

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Macular Degen.
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ Cancer
- ☐ 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 "test drive" 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

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** Your information is protected by our privacy policy**.**
I have received a copy of Spectrum Optical "Notice of Privacy Practices".

Remind me of my appointment by: ☐ Text

Signature_____ Date_____

Relationship to Patient: _____