

Welcome to Greenspan Family Eyecare

Established Patient Information & Questionnaire

Date: _____ Date of Birth: _____
 Last Name: _____ First Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home #: _____ Age: _____
 Work #: _____ Sex: Male Female
 Cell #: _____ Email: _____
 Occupation: _____ Social Security: _____
 Primary Care Physician: _____ Date of last Exam: _____
 Reason for today's Visit: _____

THERE IS A FEE FOR EVALUATION OF YOUR CURRENT CONTACT LENSES

Eye History

Do you currently, or have you ever had problems in any of the following areas?

PLEASE, LIST ANY CHANGES

- | | | | |
|-------|---------------------------------------|-------|----------------------|
| Y / N | Blur at: Distance/Near/Mid-range | Y / N | Cataract |
| Y / N | Eyestrain/ Tired eyes | Y / N | Glaucoma |
| Y / N | Double Vision | Y / N | Macular Degeneration |
| Y / N | Crossed/ Lazy eye | Y / N | Retinal Detachment |
| Y / N | Eye Discomfort- circle all that apply | Y / N | Flashes of light |
| | Redness | Y / N | Floaters in vision |
| | Dryness | Y / N | Eye injury |
| | Itching | Y / N | Eye surgery _____ |
| | Watery | | |
| | Sandy/Gritty | | |
| | Painful | | |
| | Light sensitive | | |

Contact Lens Wearers:

How often do you sleep or nap in your contact lenses? _____

How often do you replace your contact lenses? _____

Solutions used: _____

General History

PLEASE, LIST ANY CHANGES

- Y / N *Women:* Are you pregnant or nursing? _____
- Y / N Are you currently taking medications? If yes, please list all, including Over The Counter medicine.

Medications:

Condition Being Treated:

Y / N Allergies to medications? _____

Y / N Do you use tobacco products? IF YES, type, amount, how long? _____

Please list any changes in your health since your last visit:

Please list any changes in your family's health history since your last visit:

Doctor's Signature: _____

Date: _____