Welcome to Greenspan Family Eyecare | Established Patient Information & Questionnaire

Date:_____**Date of Birth:**_____**Please circle: Mr. Mrs. Ms. Miss Dr.**

Last Name:_____ **Legal First Name:**_____**M.I.**_____

Address:_____

City:_____ **State:**_____**Zip Code:**_____

Home:_____ **Age:**_____**Height:**_____**Weight:**_____

Work:_____**Sex(circle): Male Female Blood Pressure:**_____

Cell:_____ **Email:**_____

Occupation:_____ **Social Security:**_____

Primary Care Physician:_____ **Date of Last Exam:**_____

Reason for Today's Visit:_____ **Referred By:**_____

Eye History

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

Y/N Blur at : Distance/ Near/ Mid-range
Y/N Glaucoma
Y/N Crossed/ Lazy eye
Y/N Floaters in Vision
Y/N Eye Discomfort – circle all that apply
Redness Dryness Burning Itching
Watery Sore Sandy/ Gritty
Painful Light Sensitive

Y/N Cataract
Y/N Double Vision
Y/N Retinal Detachment
Y/N Eye Injury

Y/N Eyestrain/ Tired Eyes
Y/N Macular Degeneration
Y/N Flashes of Light
Y/N Eye surgery_____

Contact Lens Wearers:
How often do you sleep in your lenses?_____
How often do you replace your lenses?_____
Solution used?_____

General History

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, what type, amount, how long? _____
Y/N Are you a former smoker? If yes, when did you quit?_____
Y/N WOMEN: Are you pregnant or nursing?_____

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

THERE IS A FEE FOR CONTACT LENS FITTING OR EVALUATION OF YOUR CURRENT CONTACT LENSES

Patient's Signature: _____ Date: _____