Welcome to our office!

FAMILY VISION CLINIC
DOCTORS OF OPTOMETRY

Name: Date:

Email:

To ensure the best care and visual solution during your visit please fill out the form below and bring it with you to your exam.

When was your last full eye exam? years ago

Have you ever had any injuries to your eyes? ◯ NO ◯ YES

Have you ever had any surgery on your eyes? ◯ NO ◯ YES

Do you currently wear contact lenses? ◯ NO ◯ YES

How many hours per day do you use a computer or handheld device? hours

What is your occupation/job?

Do you have any hobbies?

Who is your family doctor?

Please list all medications and vitamins, including eye drops, which you currently take:

Please list any drug or environmental allergies that you have:

Do you have any *family history* of:

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Eye Disease (please describe):

Do *you* have:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease

How did you hear about our office?

- ◯ word of mouth
- ◯ phone book
- ◯ yellowpages
- ◯ location
- ◯ google search
- ◯ radio
- ◯ other (please tell us!)

Would you like more information about:

- ☐ contact lenses
- ☐ prescription sunglasses
- ☐ non-glare lenses
- ☐ progressive lenses
- ☐ ultra thin lenses
- ☐ transition lenses (lighten and darken automatically)
- ☐ other (please ask us!)

◯ I consent to Family Vision Clinic contacting me by email to provide information about the following checked topics. I understand my email address will not be shared with any third-parties.

- ☒ appointment reminders
- ☒ glasses orders
- ☒ contact lens orders
- ☒ new product information

◯ I do NOT want to be contacted by email.

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