EYESHAPES HOBOKEN INFORMATION FORM

Todays Date: _____/_____/_____

Name: _____ Date of Birth:_____/_____/_____

Address:_____ City: _____State:_____ Zip:_____

Phone:(home):_____ (work):_____ Email:_____

Occupation:_____ Employer:_____

Who may thank for referring you? _____

Do you wear eyeglasses? Yes [ ], No [ ] Do you wear contact lenses? Yes [ ], No [ ]
If you wear contact lenses: Soft [ ], Hard [ ]? Do you replace them: Daily [ ], 2 week [ ], Monthly [ ]?
Are you interested in Laser Vision Correction? Yes [ ], No [ ]?

Reason for today's visit: _____

When was your last eye examination? _____

Do you use a computer? Yes [ ], No [ ] If, YES, do you have: Blurry vision [ ], Eyestrain [ ]?

If you wear eyeglasses, are you bothered by: the Weight [ ], Thickness [ ], Glare [ ]?
Do you wear sunglasses? Yes [ ], No [ ]. If YES: Prescription [ ], Non Prescription [ ]?

VISUAL SYMPTOMS (please check if you have:)

distance blur [ ], near blur [ ], discomfort [ ], eye strain [ ], headache [ ], double vision [ ]
turned eye [ ], burning [ ], itch [ ], redness [ ], discharge [ ], dryness [ ], light sensitive [ ]
color deficiency [ ], floaters (spots) [ ], flashes [ ], eye injury [ ], cataracts [ ], glaucoma [ ]

HEALTH HISTORY (please check if you have:)

diabetes [ ], high blood pressure [ ], heart disease [ ], thyroid [ ], cancer [ ], allergy [ ], migraine [ ]

WOMEN, are you currently: pregnant [ ], breast feeding [ ]?

Please list medications (prescription or OTC): _____

FAMILY HISTORY (check if parents or siblings have:)

cataracts [ ], glaucoma [ ], high blood pressure [ ], diabetes [ ]

Payment is expected when services are rendered, and for materials ordered and/or dispensed. Patient is responsible for any fees not paid by insurance (vision plan).

Signature (parent/guardian sign for minor):_____