WELCOME TO VIVA EYE CARE

Today's Date _____/_____/_____

PATIENT HISTORY

Name (Last, First): _____ (MI)_____

D.O.B:_____/_____/_____ Age_____ Gender ____F ____M

Address_____ City_____ State_____ Zip Code_____

Home Phone:_____ Cell Phone:_____

Occupation/Grade_____ Email:_____

How did you hear about us? _____

INSURANCE INFORMATION

Insured's Name (Last, First): _____ D.O.B: ____/____/____

Social Security #: _____ -_____ - _____

Medical Insurance: _____ Vision Insurance: _____

VISUAL AND MEDICAL HISTORY

Reason for today's visit: € Glasses exam € Contact Lens exam € Red Eyes
€ Other: _____

Date of last eye exam: _____

Are you interested in learning about Lasik Surgery? € Yes € No

Date of last medical exam: _____ Name of PCP: _____ Phone Number_____

Medications you are currently taking (including over-the-counter): _____

Are you pregnant or planning on becoming pregnant? € Yes € No Do you smoke? € Yes € No

Do you suffer from any allergies? _____ Seasonal allergy: € Yes € No

Please check the following that apply to you and/or your immediate family members:

	SELF	FAMILY		SELF	FAMILY
Diabetes	€	€	Eye Injury	€	€
High Blood Pressure	€	€	Floaters/Flashes	€	€
Arthritis	€	€	Double Vision	€	€
Thyroid	€	€	Headaches	€	€
Heart Disease	€	€	Lazy Eyes	€	€
Respiratory Problems	€	€	Cataract	€	€
Kidney Disease	€	€	Glaucoma	€	€
Cancer	€	€	Retinal Disease	€	€
Other:_____	€	€	Macular Degeneration	€	€
Surgery: _____	€	€	Eye Surgery	€	€

Do you have: *Dry Eyes? € Yes € No *Itchy Eyes? € Yes € No *Excess Tearing? € Yes € No

Do you skip lines or lose your place when reading? € Yes € No

Do you get headaches when reading? € Yes € No

CONTACT LENS INFORMATION

Do you currently wear contact lenses? € Yes € No If yes, what brand? _____

What power? _____ Do you sleep in your contacts? € Yes € No

How often do you replace your contact lenses? _____