

NEW patients to our office, please complete all of the questions below.

EXISTING patients, please update your paperwork with any **CHANGES** to your history since your last exam, or check the box below.

I am an existing patient at TruSight Optometry, there have been **NO** changes to my vision or medical history since my last exam.

Which corrective lenses do you use for daily activities?

Please circle:

No correction Glasses Contacts Both

Describe your current vision (WITH correction if worn)

Please circle:

Acceptable Needs improvement Blurred

Are you having any of the following vision concerns?

Circle "YES"

Blurred Vision YES
 Eyestrain YES
 Eye pain YES
 Severe light sensitivity YES
 Headaches YES
 Poor night vision YES
 Bothersome night glare YES
 Double vision YES
 Total loss of vision YES

Has a doctor diagnosed you with any of these eye conditions?

Circle "YES"

Cataract YES
 Age-Related Macular Degeneration YES
 Glaucoma YES
 Diabetic Retinopathy YES
 Dry Eye Syndrome YES
 Eye Infection or allergy YES
 Floaters and/or flashes of light YES
 Iritis or Uveitis YES
 Retinal Detachment or degeneration YES
 Have you ever suffered an eye injury? YES
 Have you ever had an eye or facial surgery? YES

Are you having any of the following eye health concerns?

Circle "YES"

Redness YES
 Burning YES
 Itching YES
 Tearing YES
 Discharge/Mucous YES

Have you ever been diagnosed with any of the following systemic or health concerns? Circle "YES"

Diabetes YES
 High Blood Pressure YES
 Heart Disease YES
 High Cholesterol YES
 Stroke YES
 Thyroid Dysfunction YES
 Cancer YES
 Asthma YES

Please list any medications taken, prescription or over the counter:

Please list any allergies you have, medication or other:

Are there any eye conditions or health problems in your family?

By signing below, I acknowledge that the information on this form has been completed to the best of my ability.



Signature: _____

Date: _____

OFFICE USE ONLY

LEE: _____

Type of Exam:

NP
EP

Glasses
Contacts

IOPs:
OD: _____
OS: _____

Current Rx:

OD: _____ Add: _____
 OS: _____ Add: _____

CLs:

Auto-Refraction:

OD: _____ Ks: _____ @
 OS: _____ Ks: _____ @