TRUSIGHT OPTOMETRY

Patient Intake Form

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:		CLs:	Auto-Refraction:	
OD: ____________	Add: _______	____________	OD: ____________	Ks: _______@_______
OS: ____________	Add: _______	____________	OS: ____________	Ks: _______@_______