WERNICK OPTOMETRY

PATIENT NAME:	SEX:
ADDRESS:	DATE OF BIRTH:
CITY, STATE & ZIP:	EMAIL: DO YOU CONSENT TO HAVING YOUR PRESCRIPTION SENT VIA EMAIL? YES OR NO (CIRCLE ONE)
HOME PHONE:	MOBILE PHONE:

Any changes to you or your family's medical history? (if so, check all that apply):

Self	Family	
❑	❑	Glaucoma
❑	❑	Cataracts
❑	❑	Macular Degeneration
❑	❑	Retinal Degeneration
❑	❑	Crossed/Lazy Eyes
❑	❑	Blindness
❑	❑	Color Blindness
❑	❑	High Blood Pressure
❑	❑	Diabetes
❑	❑	Heart Problems
❑	❑	Stroke
❑	❑	Thyroid Condition
❑	❑	Arthritis
❑	❑	Tuberculosis
❑	❑	HIV/Hepatitis
❑	❑	Cancer
❑	❑	Neuromuscular
❑	❑	Asthma/ Allergies
❑		Currently pregnant
❑	❑	Other:

_____

_____

Please list new symptoms (check all that apply):

- ❑ Blurry distance vision
- ❑ Blurry Near Vision
- ❑ Poor night vision
- ❑ Eye Strain
- ❑ Trouble Reading
- ❑ Itchy Eyes
- ❑ Discharge
- ❑ Watering
- ❑ Pain in the eye
- ❑ Burning eyes
- ❑ Sandy/dry eyes
- ❑ Red Eyes
- ❑ Glare/reflections
- ❑ Discomfort in sunlight
- ❑ Double vision
- ❑ Floaters or spots in vision
- ❑ Flashes of light
- ❑ Eye injury
- ❑ Headaches

Are you interested in any of the following? (check all that apply):

- ❑ A new prescription
- ❑ Contact lenses
- ❑ Sunglasses
- ❑ Vision therapy
- ❑ Dry eye treatment
- ❑ Myopia control

ANY CHANGES IN INSURANCE? IF SO, PLEASE LIST BELOW:

Insurance Carrier:
_____

ID number:
_____

Group number:
_____

ANY CHANGES TO MEDICATIONS? IF SO, PLEASE LIST BELOW:

- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____

ANY NEW ALLERGIES? IF SO, PLEASE LIST BELOW:

- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____

WERNICK OPTOMETRY

What brings you in today?

_____

_____

Circle Yes or No (Y or N) below:

1. Do you see blurry/unclear in the distance with your glasses/contacts? ---------- **Y / N**

2. Do you see blurry/unclear when you read with your glasses/contacts? ---------- **Y / N**

3. Do you have double vision when reading or doing close work? ---------- **Y / N**
   When?_____

4. Do your eyes feel tired or uncomfortable when reading or doing close work? ---------- **Y / N**
   After how long?_____

5. Do you feel a “pulling” feeling around your eyes when reading or doing close work? ---------- **Y / N**

6. Do you have headaches when reading or doing close work? ---------- **Y / N**

7. Do you feel sleepy when reading or doing close work? ---------- **Y / N**

8. Do you lose concentration when reading or doing close work? ---------- **Y / N**

9. Do you have trouble remembering what you have read? ----------**Y / N**

10. Do you see the words move, jump or swim on the page when reading/doing close work? ---------- **Y / N**

11. Do you feel like you read slowly? ---------- **Y / N**

12. Do words blur or come in and out of focus when reading or doing close work? ---------- **Y / N**

13. Do you find yourself re-reading sentences or paragraphs? ---------- **Y / N**

14. Do you ever find yourself skipping lines or words when you read? ---------- **Y / N**

15. Does your mind wander when you read? ---------- **Y / N**

16. Do you need frequent rest periods when you read? ---------- **Y / N**

17. Do you have difficulty making judgments while driving? ---------- **Y / N**

18. How many hours do you spend doing close work daily? _____