



Eye Trends Meyerland Plaza & Town Square

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Therapeutic Optometrists

Patient Information

Please take a moment to complete the information below. This helps us to provide you with the quality care and service you deserve. If we can be of assistance, please do not hesitate to ask.

Date <input type="text"/>	Preference of Doctor <input type="text"/>	Office Location <input type="text"/>
Patient's Name <input type="text"/>	Gender <input type="text"/>	Age <input type="text"/> Date of Birth <input type="text"/>
Home Phone <input type="text"/>	Work Phone <input type="text"/> Ext <input type="text"/>	Email Address <input type="text"/>
Home Address <input type="text"/>	Apt # <input type="text"/>	Social Security Number <input type="text"/>
City <input type="text"/>	State <input type="text"/> Zip <input type="text"/>	Driver's License Number <input type="text"/>
Employer <input type="text"/>	Occupation <input type="text"/>	

<p>What prompted your visit today? Is there any special issue with your eyes that is of concern?</p> <input type="text"/>	<p>Method Of Payment:</p> <p> <input type="radio"/> Cash <input type="radio"/> Credit <input type="radio"/> Check <input type="radio"/> Insurance </p>
<p>What activities commonly affect your eyes? i.e., computer, driving, long hours in sunlight...</p> <input type="text"/>	<p>How did you hear about us? i.e., Family, Friend, Web Site...</p> <input type="text"/>

Family Health History check all applicable items...	Your Health History Please check if you have had...	Your Visual Symptoms Please check if you have had...
<ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Sensitivity <input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Skin Condition <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Poor Color Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Turned eye 	<ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Sensitivity <input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Skin Condition <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Poor Color Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Turned eye 	<ul style="list-style-type: none"> <input type="checkbox"/> Distance Vision Blurry <input type="checkbox"/> Near Vision Blurry <input type="checkbox"/> Discomfort with distant tasks <input type="checkbox"/> Discomfort with near tasks <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Double Vision <input type="checkbox"/> Variable Vision <input type="checkbox"/> Temporary loss of Vision <input type="checkbox"/> Flashing lights <input type="checkbox"/> Black spots or floaters <input type="checkbox"/> Eye Strain <input type="checkbox"/> Headaches related to eyes <input type="checkbox"/> Burning eyes <input type="checkbox"/> Itching eyes <input type="checkbox"/> Watery Eyes <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Twitching Eyelids <input type="checkbox"/> None -- routine exam

Please explain or elaborate on any issues with your health history:

Pupil Dilation

In order to examine the entire eye, we must dilate the pupil. Examining the eye is like trying to look into a room through a keyhole. By enlarging the pupil, the doctor is able to clearly see the areas within the eye. Gentler drops now provide the means for a quick, painless examination with minimal side effects; you may experience a temporary dryness of the eye, some blurring of near vision, and some light sensitivity for a period of three to five hours. Many types of eye disease and injury can go undetected without dilation. As with any disease, early diagnosis is essential to successful treatment and prevention of future complication.

May we have permission to dilate your eyes?

- Yes No Will discuss with doctor

Medications

Are you taking any medications?

Are you allergic to any medications?

Date of last physician visit

Physician's name w/ phone

Date of last eye exam

Previous eye doctor or office w/ phone #

Have you ever had any eye disease, injury or surgery?

Have you ever worn contacts? yes no

Are you interested in contacts? yes no

Are you interested in laser vision correction? yes no

The following lens options can maximize your vision. Please indicate any that you wish to discuss with the Doctor or Optician.

If yes, what type?

- Disposable, Daily
- Disposable 2-week
- Disposable 1-month
- Disposable 3-month
- Conventional (reusable)
- Bifocal
- Colored
- Hard/Gas Permeable
- Torics (for astigmatism)

- Ultraviolet Protection
- Progressive Multifocals
- Bifocals (Flat top)
- Trifocals
- Sports Glasses
- Polycarbonate Lenses (for safety and impact resistance)
- Transitions (Lenses that darken in the sun)
- Aspheric Lenses (reduces distortion and magnification of the eyes)
- Polarized Lenses (ideal for fishing and water sports)
- Polished lenses
- Computer Glasses
- Scratch resistance lenses
- Hi-Index (thinner and lighter) lenses
- AR (glare free) lenses