



PERFECT FOCUS
EYECARE

Patient Name: _____ Date of Birth: _____ Male/Female
Today's Date: _____

Home Address:
Street: _____ City: _____ State: _____ Zip Code: _____

Phone: Home (_____) _____ Cell (_____) _____ Email _____

How did you hear about us? _____
Occupation: _____

Name of Insurance: _____
Primary Cardholder: _____
Primary D.O.B.: _____
Subscriber/Member I.D. _____

Date of Last Eye Exam: _____ Do you wear glasses, contacts or both? **(circle one)** Do you use a computer? **Y/N**

Reason for today's visit: _____

Medication Allergies: _____ Seasonal Allergies: Yes/No

Medications (Please List): _____
Eye Medications (Please List): _____
Are you pregnant or nursing? Yes/No

Do you see flashes of light in your vision? **Yes/No**
Do you see floating objects in your vision? **Yes/No**
Do you suffer from temporary black outs of your vision? **Yes/No**
Do you experience double vision? **Yes/No**

Have you been diagnosed or treated for any medical conditions? If yes, please explain.

Have you been diagnosed or treated for any eye diseases? If yes, please explain.

Have you had any surgery on your eyes? If yes, please explain.

Has anyone in your immediate family been diagnosed or treated for:

Glaucoma: **Yes/No** Lazy eye: **Yes/No**
Diabetes: **Yes/No** Retinal Problems: **Yes/No**
Cataracts: **Yes/No**
Macular Degeneration: **Yes/No**