

# Innovision Eye Care

## General Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ M \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation/School Grade: \_\_\_\_\_

## CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Physician/Clinic: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Clinic/Eye Doctor's Name: \_\_\_\_\_

Do you wear glasses? Yes/No/All the time/Sometimes/Work only/Reading only/Driving only

Do you always like to wear your glasses? Yes No

Do you wear bifocals? Yes No

If yes, are you bothered by head tilting, restricted areas of vision correction, etc? Yes No

Do you want information on thinner, lighter lenses? Yes No

Do you have problems with glare or reflections, particularly when driving at night? Yes No

Do you work on a computer for 3+ hours a day Yes No

Do you spend time outdoors? (Hours per week: \_\_\_\_\_ ) Yes No

Do you have prescription sunglasses? Yes No

Do you have family members in need of eyecare? Yes No

Are you interested in contact lenses? Yes No

Have you ever worn/are you currently wearing contacts? Yes No

What kind? \_\_\_\_\_ Solutions used \_\_\_\_\_

Do you have questions on refractive surgery? Yes No

Have you ever had eye injuries? Yes No Which Eye? \_\_\_\_\_

Have you ever had eye surgeries? Yes No Why? \_\_\_\_\_

Have you used eye medication? Yes No Why? \_\_\_\_\_

Are you currently pregnant or nursing? Yes No N/A

## Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed? \_\_\_\_\_

Glaucoma: Yes/No When were you diagnosed? \_\_\_\_\_

Macular Degeneration: Yes/No When were you diagnosed? \_\_\_\_\_

## What are your visual symptoms: Please circle any that apply:

Blurred Vision/Distance	Burning Eyes	Floaters or Spots	Headaches
Blurred Vision/Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive
Eye Pain/Soreness	Wandering eye	Droopy Lid	Sandy/Gritty Feeling
Tired eyes	Mucus Discharge	Dizziness	Nausea