Welcome Back!
Sager Eye Care Center

In order to provide you with the best possible eye care, please answer the following questions:

Primary Care Physician: ________________________ Occupation: ________________

Date of last physical exam ____________

Please state the main reason for today's visit:

____

____

Have you had your eyes examined by another doctor since your last visit at this office ? ___ Yes ___ No

If yes, when? ________________ Name of Doctor ________________________________

Eye Health History

Are you experiencing any of the following :

- ○ Blurry vision
- ○ Redness
- ○ Ocular discharge
- ○ Eye pain/soreness
- ○ Chronic Infection of the eye or eyelid
- ○ Sties or Chalazion (Bumps on your eyelid)
- ○ Dryness
- ○ Burning
- ○ Tearing/watering
- ○ Itchiness
- ○ Grittiness
- ○ Foreign body sensation
- ○ Distorted Vision
- ○ Loss of any vision
- ○ Flash of light
- ○ Floaters/Spots
- ○ Trouble seeing at night
- ○ Glare/light sensitivity
- ○ Halos around lights or starbursts
- ○ Tired eyes
- ○ Excessive blinking
- ○ Neck/shoulder pain at computer
- ○ Headaches
- ○ Dizziness
- ○ Double Vision
- ○ Crossed eyes/eye turn

Have you ever been diagnosed or treated for the following:

- ○ Glaucoma
- ○ Corneal Abrasion
- ○ Cataracts
- ○ Eye Injury
- ○ Eye Infection
- ○ Iritis / Uveitis
- ○ Lazy Eye
- ○ MacularDegeneration
- ○ Detachment
- ○ Other eye disorders ________________ ________________

Date of any Surgery _________ Reason for Surgery ________________________________

By whom? ____

Medical History

Current Medications (Rx or over the counter) List name of medications including eye drops vitamins & birth control pills:

____

____

____

____

Do you have any allergies including to medications? Yes No If Yes, please explain:

____

____

Are you currently pregnant or nursing? Yes No

Have you have ever been diagnosed or treated for the following?

- ○ Cholesterol
- ○ Cancer
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Thyroid
- ○ Nerves
- ○ Arthritis
- ○ Asthma
- ○ Diabetes
- ○ Kidney
- ○ Other ________________ ________________

Lifestyle Do You...

(check all that apply)

- ○ Work at a computer?
- ○ CONTACT LENS WEARERS: Is there anything you would change about your contacts?
- ○ Have interest in CONTACT LENSES? ____Clear ____ Colored
- ○ Want information on vision correction surgery/laser vision/ Lasik Correction ?
- ○ Spend time outdoors?
- ○ Have interest in updating your eyeglass frames?
- ○ Have prescription sunglasses?
- ○ Think you might benefit from thinner, lighter lenses?

Social History

The following information is kept strictly confidential. However you may discuss this information directly with your doctor if you prefer.

○ *Yes, I would prefer to discuss my social history information directly with my doctor (check box)*

Do you use tobacco products? Yes No If yes, type/amount/how long? ________________

Do you drink alcohol? Yes No If yes, type/amount/how long? ________________

Do you use illegal drugs? Yes No If yes, type/amount/how long? ________________

Have you ever been exposed to or infected with:

- ○ Gonorrhea
- ○ Hepatitis
- ○ HIV
- ○ Syphilis

◆ Please be aware that during the exam if a medical diagnosis is found, we may need to use your medical insurance due to the fact that your vision insurance will not cover some services.

Print Name: ________________ Sign: ________________________ Date: ________