Virtual EyeCare

Doctors of Optometry

NAME: _____**Date of Birth:** ____/_____/____

Email: _____ **Mobile phone**:_____

Current Medications: _____

_____

Allergies to medications: _____

Current medical history (i.e. high blood pressure, cholesterol, thyroid disease, stroke, COPD etc.)

_____

_____

Are you Pregnant or Nursing?_____

Diabetics please answer the following:

Type I or Type II

How many years have you had Diabetes?_____

What is your Last A1C number? _____

Who is your Primary Care Physician?

_____

City and Clinic name for Primary Care Physician

_____

CONTACT LENSES

What brand of lenses are you using?

_____

How many hours per day do you wear your lenses?

_____

How many nights per week do you sleep in your lenses?_____

By signing I acknowledge I have received a copy of my contact lens RX

_____

Please circle all that apply:

Blurred vision
Flashes of light
Floaters
Headaches
Dryness
Sandy/Gritty feeling
Redness
Watering
Itching
Eye Pain
Light Sensitivity
Glare/Halos
Cataracts
Glaucoma
Family History of Glaucoma
Macular Degeneration
Family History of Macular Degeneration
Current smoker
Former smoker
Previous LASIK
Previous Cataract surgery
Previous Retinal surgery
Previous Eye muscle surgery
Previous Eye Patch use

By signing below I acknowledge that I have been offered a copy of Virtual EyeCare Privacy Policies

Signature_____ **Date** ___ /____ /_____