

Eye to Eye Vision
Ted. N. Trumbore, O.D.
Contact Lens Specialist
Welcome to our practice
Please print

NAME _____

DATE _____

ADDRESS _____

DATE OF BIRTH ____/____/____

SSN ____-____-____

EMPLOYER _____

INSURANCE _____

PHONE (H) _____

SUBSCRIBER _____

(W) _____

SUBSCRIBER ID # _____

OCCUPATION _____

SUBSCRIBER DOB ____/____/____

RESPONSIBLE PARTY _____

GROUP # _____

MEDICAL INSURANCE _____ SUBSCRIBER ID # _____ GROUP # _____

Have you ever worn glasses? Y ___ N ___ How are they used? Distance ___ Near ___ Constantly ___

Have you ever worn contact lenses? Y ___ N ___ How long? _____ Type? Soft ___ Extended ___
Disinfection system _____ How old are your current lenses? _____ Gas Permeable ___

Approximate date of last exam _____ Previous eye doctor _____
Recommended by _____

Your reasons for visiting our office today (Please check appropriate items)

- | | | |
|---|---|--|
| <input type="checkbox"/> General check up | <input type="checkbox"/> Eyes Water | <input type="checkbox"/> Want contact lenses |
| <input type="checkbox"/> Lost or broke glasses | <input type="checkbox"/> Glare | <input type="checkbox"/> Want bifocal contact lenses |
| <input type="checkbox"/> Want new glasses | <input type="checkbox"/> Eyes burn | <input type="checkbox"/> Contact lens check up |
| <input type="checkbox"/> Blurred distance vision | <input type="checkbox"/> Eyes itch | <input type="checkbox"/> Problem w/ contact lenses |
| <input type="checkbox"/> Blurred intermediate vision | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Other (please list) _____ |
| <input type="checkbox"/> Blurred near vision | <input type="checkbox"/> Pain in eyes | _____ |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> See "spots" | _____ |
| <input type="checkbox"/> Headaches - when & how often _____ | <input type="checkbox"/> Foreign body sensation | _____ |
- (Something in your eye) _____

Hobbies _____

GENERAL AND OCULAR HEALTH

- | | | | | |
|------------------------------------|---|---|---|-----------------------------------|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> "Crossed" eyes | <input type="checkbox"/> "Lazy" eye | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Retinal disorders | <input type="checkbox"/> Eye injuries | <input type="checkbox"/> Eye surgery | |

Other (please list) _____

Have any of your relatives had any of the above conditions? Y ___ N ___ Please list _____

Are you presently taking any medications? Y ___ N ___ Please list _____

Are you allergic to any medication or eye drops? Please list _____

Have your eyes been dilated before? Y ___ N ___ If so, when? _____ Family doctor _____