

Eger Eye Group, P.C.

Last name: _____ Middle Initial: _____ First Name: _____ Birth Date: _____
 Street Address: _____ City/State/Zip: _____
 Home Phone: (____) _____ Work Phone:(____) _____ Email: _____
 Occupation: _____ Employer: _____ Soc. Sec. #: _____
 Age: _____ Sex: _____ Race: _____ Marital Status (circle): Single Married Divorced Separated Widowed
 Who may we thank for referring you: _____ Primary Care Physician: _____
 In case of emergency please notify: _____ Phone: (____) _____

Primary reason for today's appointment: _____

Do you wear glasses: _____ Contact Lenses: _____ Type: _____

Have you had eye surgery: _____ What kind: _____ Date: _____

Have you had an eye injury: _____ What kind: _____ Date: _____

Do you have (circle): Glaucoma Cataracts Macular Degeneration Dry Eyes Blurred Vision Headaches Flashes Floaters Pain
Double Vision Discharge Redness Lazy Eye Sandy Itching Burning Tearing Infection Tired Eyes Eyelid Droop Other

Please explain any other eye and/or visual conditions: _____

Is there a family history of: Amblyopia/lazy eye Diabetic Eye Disease Glaucoma Macular Degen. Retinal Detachment Other.

Please list all medications you take: _____

Please list all medical conditions &/or surgeries: _____

Allergies (Drug &/or Environmental): _____

Do you use (circle): Cigarettes/tobacco alcohol caffeine narcotics Date of last physical : _____

Are you currently having or have you had recent problems with:

Circle one

Circle one

Blackout/fainting	No	Yes	Headache/dizziness	No	Yes
Bladder/bowel movement/ urination	No	Yes	High blood pressure	No	Yes
Bleeding problems	No	Yes	Lower back pain	No	Yes
Changes in skin color/texture/rash	No	Yes	Lungs, Breathing/cough	No	Yes
Chest pain/palpitation	No	Yes	Muscle/bone/joint pain	No	Yes
Digestion/Abdominal Pain	No	Yes	Numbness/tingling	No	Yes
Ears, Nose, Throat, Ringing of Ears	No	Yes	Anxiety/Nervousness/Depression/Fatigue	No	Yes
Fever, chills, sweats, swollen glands	No	Yes	Weight loss or gain	No	Yes

Please describe all "yes" answers: _____

Patient or Parental Signature: _____ **Date:** _____

Reviewed by Doctor's Signature: _____ **Date:** _____



Your Vision Lifestyle!

Welcome! You are here because you care about your vision and we're here because we care too! Please fill out this brief questionnaire so that we can better help you to protect that vision as well as care for the overall health of your eyes.

Name _____

Date _____

Please circle how often you currently wear the following forms of sight correction and/or sight protection...

Contact Lenses	Always	Often	Rarely	Never
Eyeglasses	Always	Often	Rarely	Never
Plano Sunglasses (Non-prescription)	Always	Often	Rarely	Never
Prescription Sunglasses	Always	Often	Rarely	Never

Your eyewear is a part of your life! It should function perfectly, look great and always feel completely comfortable! Do you have any of the following problems with your current eyewear? Please check all that apply.

- Too heavy (They leave marks on nose or cheeks.)
- Poor fit (They slip down or are uneven.)
- Squeeze too hard on the temples
- Wrong size (too large or too small)
- Difficulty with bifocal
- Too much glare
- Irritating under fluorescent lights
- Inadequate amount of reading area in the lenses
- Need constant adjustment
- Outdated, faded or worn out
- Screws fall out too easily
- Other, please comment:

Please tell us what you do! Just circle your participation level in the following activities and indicate whether or not you currently have eyewear specific for that activity.

<u>At Home / Work:</u>	<u>I have eyewear for this activity</u>					
Reading	Frequently	Infrequently	Never		Yes	No
Computer	Frequently	Infrequently	Never		Yes	No
Television	Frequently	Infrequently	Never		Yes	No
Other (musical instruments, hobbies, etc.):						
_____	Frequently	Infrequently	Never		Yes	No
<u>Outside:</u>						
Driving	Frequently	Infrequently	Never		Yes	No
Cycling	Frequently	Infrequently	Never		Yes	No
Walking/Jogging	Frequently	Infrequently	Never		Yes	No
Golf	Frequently	Infrequently	Never		Yes	No
Tennis	Frequently	Infrequently	Never		Yes	No
Water Sports	Frequently	Infrequently	Never		Yes	No
Snow Sports	Frequently	Infrequently	Never		Yes	No
Other:						
_____	Frequently	Infrequently	Never		Yes	No

Do you have any other special visual needs? If so, please describe:

