Welcome to our Office!

Name____ Date of Birth______________________

Address_____________________________________ City______________________ Zip_________

Phone _______________________________ Email _______________________________________

Occupation/Student ________________________Employer/School______________________________

Hobbies / Recreational Activities ____

Main Reason for Today's Exam____

Any vision related concerns / needs?____

Date of Last Eye Exam___________________________ Were eyes dilated? Yes No

In the past have you had (please Check)

____ glasses ____soft contacts ____ rigid gas perm contacts ____ vision correction surgery ____ none

Please indicate all that pertain to your eyes (X) or to an immediate family member's eyes (F):

____surgery ____retinal detachment ____eye turn ____color blindness
____cataracts ____macular degeneration ____lazy eye ____flashes / floaters
____glaucoma ____injury / head trauma ____herpes ____double vision

Do you regularly use a computer? Yes / No If Yes :________hours per day For: Business / Leisure

During or after computer use do you notice any of the following?

____eye fatigue ____dry/burning feeling ____red eyes ____blurred vision ____headaches

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Have you ever been diagnosed or treated for:

____High Blood Pressure ____Arthritis ____Allergies ____Heart Attack ____Diabetes ____Stroke
____High Cholesterol ____Hepatitis ____Asthma ____Blood Disorder ____Medication Allergies
____Headaches / Migraines ____Depression / Anxiety ____Multiple Sclerosis Other ______________________
____Autism Spectrum Disorder

Current Medications____

Over the Counter Eyedrops (Allergy etc.) ____

Whom may we thank for referring you?____

To whom would you like a report sent?____

In order to provide a thorough exam, dilating eye drops may need to be used.
These eye drops may cause light sensitivity and blurred vision.

_____I give my permission for eye drops to be used *(or)* _____ I understand the reason for drops but refuse them today

I acknowledge receipt of Visual Edge LLC's Notice of Privacy Policies.

Eye exam charges are due in full at time of service, and are non-refundable. Visual Edge, LLC will be happy to assist you in paperwork for reimbursement from your insurance company. **We do not bill insurance companies directly.**

Please Sign: Patient or Guardian ____Date____________

Visual Edge LLC

Name____Date of birth______________________________

Primary Care Physician's name & address____

Were you a full term pregnancy?____

Any complications during pregnancy?_______________________________________Did you crawl? ____Yes ____No

Did/Do you like school? ____Yes ____No Did/Do you perform to your potential? ____ Yes ____ No

Is/Was school work _____average _____above average _____below average

Were any grades repeated? _____Yes ____No If yes, which grade?___________________

Have you been diagnosed with a learning problem?____

Has you ever had a concussion? _____Yes ____No If yes, when?___________________________________

Do you have : _____headaches _____blurred vision at distance _____light sensitivity

_____eyes hurt or tired _____double vision _____blurred vision at near

Have you noticed any of the following?

_____holding reading material close _____holding reading material far _____closing one eye

_____covering one eye _____eyes frequently red _____eye rubbing

_____using finger to keep place _____poor posture when reading _____poor coordination

_____skipping or rereading words _____reversing words / letters _____tilting head to read

_____moving head while reading _____moving lips while reading quietly _____confusing right and left

_____eye shaking Which eye?______________When?____

_____eye turn Which eye?______________ When did it first start?________________________________

Which direction? Up / Down / Out / In Is it occurring less often / more often / the same?

When do you usually notice it?____

Have you ever received occupational or physical therapy?________________________________

____

What do you hope to learn from this exam?____

____

____

Is there any other information that you feel may be useful?____

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