PEEPERS FAMILY EYECARE

Welcome to Peepers. In order to provide you with the best care, please complete the following information. Our staff will be glad to assist you if you have any questions.

Today's Date: _____/_____/_____

Name: _____ Date of Birth: _____ Age:_____

Current Address:_____

City, State Zip _____ If Child (Guardian Name) _____

Email address: _____ SSN# _____

Home Phone: _____Wk Ph: _____ Cell Ph: _____

Occupation: _____ Married [ ] Partnered [ ] Single [ ] Student [ ]

Who may we thank for referring you to our office?_____

Patient History Information

During your visit today please circle if you would like a prescription for: Glasses Contact lenses
Have you worn glasses? Yes [ ] No [ ] If so, how old are your current glasses? _____yrs.
Have you worn contact lenses? Yes [ ] No [ ] If so, how old are your contacts? ____. Type of contacts?_____

To provide you with the best care possible, we need the following information:

Medications:

Please list any medications you are taking and what they are for: _____
_____
_____

Please list any allergies to medications you are aware of:
_____
Who is your medical doctor? _____ Date of last exam: _____
Who was your last optometrist? _____ Date of last eye exam:_____

Medical Information: Please place a **check** in the blank if the described condition applies to you.

Allergies
Do you have seasonal allergies? ____
Itchy eyes? ____
Chronic sinus infections? ____

Medical Health
Do you have high blood pressure? ____
A history of stroke? ____
Diabetes? ____
High cholesterol? ____
Asthma or lung problems? ____
Arthritis ____
Thyroid condition? ____
HIV or AIDS? ____

Family History
Glaucoma? ____
Diabetes? ____
Loss of Vision? ____
Macular Degeneration? ____
High Blood Pressure? ____

Neurological ____
Do you have frequent headaches? ____
Migraines? ____

Ocular Muscles
Do you have strabismus (turned eye)? ____
Prism in your glasses? ____
Did you ever have vision therapy? ____
Do you ever see double? ____

Ocular Health?
Do you have glaucoma? ____
Do you have amblyopia (lazy eye)? ____
A history of ocular trauma ____
Watery /Burning eyes? ____
Cataracts? ____
A history of an eye surgery? ____
Floaters? ____
Have you ever had a retinal detachment? ____
Macular degeneration? ____
Gritty or Sandy Feeling in the eyes? ____

Optical
Do you have problems with glare? ____
Work on a computer? ____
Participate in sports? ____
Blurred vision with current glasses ____

Are you interested in LASIK? ____

Have you ever had head trauma? ____
Is there any additional information about your **visual** or **medical** health we should know about you?
If so, please explain here: _____
_____