LIFETIME EYECARE
YOUR VISION SOURCE

Welcome to Our Office _____!

To insure we prescribe everything you need for your eyes today we want to know how you use your eyes and how they feel.

Allergies	☐Yes	☐No	Asthma	☐Yes	☐No	Arthritis	☐Yes	☐No	Cancer	☐Yes	☐No
Diabetes	☐Yes	☐No	Glaucoma	☐Yes	☐No	Eye Diseases	☐Yes	☐No	Eye Injury	☐Yes	☐No
Eye Surgery	☐Yes	☐No	Heart Disease	☐Yes	☐No	High Blood Pressure	☐Yes	☐No			

Current Physician:_____ Specialty Physician:_____

Do you wear contact lenses? ☐Yes ☐No ☐Interested in Trying
If so do you have current glasses? ☐Yes ☐No
If so do you have polarized sunglasses? ☐Yes ☐No

Top three activities you are involved in or spend your time doing:

_____ _____ _____

How much time do you spend on a computer/cell phone/playing video games/I pad/tablet?

☐0-2 Hours per Day ☐2-4 Hours per Day ☐More than 4 Hours per Day

Rate the comfort of your eyes between **5 (most comfortable) and 1(uncomfortable):**

1 2 3 4 5

Do your eyes feel dry? ☐Yes ☐No

Do your eyes ever get blurry? ☐Yes ☐No

Do you use eye drops? ☐Yes ☐No

Do your eyes ever itch/burn/water? ☐Yes ☐No

Do you currently take fish oil? ☐Yes ☐No

Do you have concerns about the lines/puffiness around your eyes? ☐Yes ☐No

How much time do you spend outside ☐Less ☐More than two hours.

Do you have polarized sunglasses? ☐Yes ☐No

Do you wish to update your glasses today? ☐Yes ☐No

Do you have any other concerns about your eyes?_____