WELCOME TO SKYLINE FAMILY EYECARE

MR. MRS. MS. MISS	LAST	FIRST	MIDDLE	DATE

ADDRESS			HOME PHONE
CITY	STATE	ZIP	WORK PHONE
DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE	OCCUPATION	CELL PHONE
EMAIL ADDRESS			SOCIAL SECURITY #

VISION INSURANCE	Policy Holder Name	Policy Holder DOB
MEDICAL INSURANCE	Policy Holder Name	Policy Holder DOB
PRIMARY CARE PHYSICIAN	How did you hear about our office?	

VISION HISTORY

When was your last eye examination? _____ By Whom? _____

Do you have any of the following:

- ☐ Blurred Vision - Distance
- ☐ Blurred Vision - Near
- ☐ Headaches
- ☐ Dizziness
- ☐ Spots/Floaters
- ☐ Itchy/Burning/Watery Eyes
- ☐ Red Eyes
- ☐ Dry Eyes

Do you wear glasses? ☐ YES ☐ NO

Do you wear contact lenses? ☐ YES ☐ NO

If YES, what type?

- ☐ Disposable
- ☐ Astigmatic Soft
- ☐ Gas Permeable (Hard)

Do you ever sleep in your contact lenses? ☐ YES ☐ NO

Are you having any problems with your contact lenses? ☐ YES ☐ NO

Are you interested in wearing contact lenses at this time? ☐ YES ☐ NO

MEDICAL HISTORY

Do You Have Any of the Following:

Diabetes	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO
Thyroid Disease	☐ YES	☐ NO
Auto-Immune Disease	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Retinal Disease	☐ YES	☐ NO
Allergies	☐ YES	☐ NO
Medication Allergies	☐ YES	☐ NO
Other Medical Conditions	☐ YES	☐ NO

Please list: _____

Please list: _____

Please list: _____

Do Any Family Members Have:

			Relationship
Diabetes	☐ YES	☐ NO	
Glaucoma	☐ YES	☐ NO	
Macular Degeneratior	☐ YES	☐ NO	
Retinal Disease	☐ YES	☐ NO	

Please List ALL Medications You Are Taking: _____