BAKER EYE CARE

Last Name:_____First Name_____MI ___ DOB:__/__/___

Date: __/__/___ M or F SSN: ___/___/_____

Address:_____City:_____ State: ____ Zip: _____

Home Ph: (___)_____ Cell Ph: (___)_____

Employer/School: _____ Occupation/grade school_____

Email address:_____ Preferred contact: Phone/Email/Postal mail/Text

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Date of last eye exam: __/__/___ Eye Doctor's Name: _____

Date of last medical exam: __/__/___ Primary care physicians name: _____

Do you wear glasses?: Y/N/sometimes/Near tasks only

Age of current classes: _____ Do you were sunglasses?: _____

Do you wear/interested in contacts?: Y/N

Have you ever had an eye injury? Y/N

Have/do you use eye drops? Y/N

Have you been diagnosed with any eye conditions such as cataracts, macular degeneration, glaucoma?

Do you have any of the following eye symptoms?

Dryness: [Y/N]	Burning: [Y/N]	Itching: [Y/N]	Pain: [Y/N]
Floaters: [Y/N]	Light flashes: [Y/N]	Red eyes: [Y/N]	Headaches: [Y/N]
Halo's: [Y/N]	Watery eyes: [Y/N]	Eye strain: [Y/N]	Light sensitivity: [Y/N]
Crossed eyes: [Y/N]	Double vision: [Y/N]	Blurred vision: [Y/N]	

Please list any medical conditions you have been diagnosed with below:

Please list any allergies you have to medications and/or environment:

_____

Please list any current medications you are taking:

_____

Please list any eye conditions and/or medical conditions your family has/had: