Reason for today's visit

_____

Name of Primary Care Doctor: _____

Name of local pharmacy: _____

Preferred Mail order pharmacy (if applicable) _____

Would you like a new glasses' prescription today? **☐Yes ☐Yes If change in RX ☐No**

Are you interested in looking at glasses today? **☐Yes ☐No**

Would you like a new contact lens prescription today? **Additional charges apply** **☐Yes ☐Yes If change in RX ☐No**

Do you currently or recently have any of the following:

During a typical day in the past month, how often did your eyes feel uncomfortable (burning, grittiness, pain)?	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
During a typical day in the past month, how often did your eyes feel dry?	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
During a typical day in the past month, how often did your eyes look or feel excessively watery?	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**

Blurry Vision	**☐Yes**	**☐No**
Redness of eye(s)	**☐Yes**	**☐No**
Double Vision	**☐Yes**	**☐No**
New or Worsening headache	**☐Yes**	**☐No**
Increased sensitivity to light	**☐Yes**	**☐No**
Irritated eyes	**☐Yes**	**☐No**
Difficult reading up close	**☐Yes**	**☐No**
Difficult reading in the distance	**☐Yes**	**☐No**
New Floaters and/ or Light Flashes	**☐Yes**	**☐No**
New Distortion of vision (e.g., straight lines look wavy) or missing spots in vision	**☐Yes**	**☐No**
Sudden loss of vision (even temporary), such as graying or blacking out of vision	**☐Yes**	**☐No**
Mucus, discharge or crusting of eye(s)	**☐Yes**	**☐No**
Drooping eyelids(s)	**☐Yes**	**☐No**
Fever or Recent Illness (cough, cold, flu)	**☐Yes**	**☐No**

If you are a contact lens wearer:

Irritation with contact lenses?	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**

How long are you wearing contact lenses before noticing irritation? _____

How long do you wear the contact lenses per day? _____

Patient Name (please print): _____ DOB: _____ Today's Date: _____