GRATITUDE VISION
OPTOMETRY

WELCOME

Name: _____ Date:_____
First Name Last Name

Date of Birth: _____/_____/_____ Age:_____ Occupation:_____
MM DD YYYY

Address: _____

Email: _____

Phone (Mobile): _____ Phone (Home): _____

Last Eye Exam: _____ Last Retinal Imaging: _____

Primary Care Physician: _____

Medication: _____ ☐ None

Allergies: _____ ☐ None

Do you currently wear or have worn contact lens in the past? ☐ Yes ☐ No

Check if applicable:

MEDICAL HISTORY:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Thyroid
- ☐ Lupus

OCULAR HISTORY:

- ☐ Eye turn/lazy eye
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Diabetic retinopathy
- ☐ Hypertensive retinopathy
- ☐ Retinal detachment

FAMILY HISTORY:

- ☐ Eye turn/lazy eye
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Retinal detachment

Please list eye conditions you experience:_____

_____

Are you interested in glasses? ☐

Are you interested in sunglasses? ☐

Are you interested in contact lenses? ☐

Are you interested in LASIK? ☐

How did you hear about us? _____