PATIENT FORM

ALEX Vision Source®
SIGNATURE EYE CARE™

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone (Home) Phone (Cell) Phone (Work)

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Date of Birth Male/Female

Employer/School Occupation/School Grade *full-time* | *part-time*

Hobbies

Language, Race, Ethnicity

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Emergency Contact Person, Relationship, and Phone

I authorize: to share in my eye health care. Date: Signature:

PERSONAL HISTORY

Reason for today's visit

Date of last eye exam / / Clinic/Eye Doctor's Name

Date of last medical exam / / Primary Physician/Clinic

Height Weight Current Tobacco Use? (circle) Yes No Past Tobacco Use? (circle) Yes No

Alcohol Use? (circle one) None Rare Social 1 Drink Daily >1 Drink Daily

Are you currently pregnant or nursing? (circle) Yes No

How many hours a day do you spend on electronic screens (phone, computer, tablet, etc) Hours:

OCULAR HISTORY

Do you wear glasses? (circle) Yes No All the Time Occasionally Office Work Reading Only Driving Only

Do you wear contacts? (circle) Yes No Type: Replacement Schedule:

Eye injuries (circle) Yes No Type of injury/which eye?

Eye surgeries (circle) Yes No Type of surgery/which eye?

Eye medications (circle) Yes No Type of med/which eye?

Have you ever been diagnosed with?

Cataracts? (circle) Yes No Lazy Eye? (circle) Yes No

Glaucoma? (circle) Yes No Retinal Detachment? (circle) Yes No

Macular Degeneration? (circle) Yes No Other Eye Condition? (circle) Yes No Explain

Are you currently experiencing, or have experienced any of the following? (circle all that apply)

Blurred Vision - Distance	Eye Infections	Red Eyes	See Halos	Poor Color Vision
Blurred Vision - Near	Burning Eyes	Watery Eyes	Poor Night Vision	Light Sensitivity
Double Vision	Itchy Eyes	Floaters or Spots	Headaches	Migraine Headaches
Eye Strain	Dry Eyes	See Flashes	Loss of Vision	Crossed Eyes

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