

Welcome to InSight Optometry & Occupational Therapy

All information is kept strictly confidential and will only be used to provide you with the best vision care possible.

| | |
|--|-------------------|
| Today's Date: _____ | Name: _____ |
| Date of Birth: _____ | Occupation: _____ |
| How did you hear about our office? _____ | |

Health & Eye History

Who is your family physician? Name: _____ City: _____

Do you have any health problems? Y N Brief description: _____

Do eye problems run in the family? Y N Brief description: _____

Do you take medication(s)? Y N Please list: _____

Do you have any allergies? Y N Please list: _____

Have you ever had eye injury, surgery or disease? Y N Brief description: _____

Are you pregnant? Y N How many months? _____

Do you take birth control pills? Y N Name: _____

Last Eye Examination:

Date: _____

Doctor: _____ City: _____

Do you wear/have you ever worn prescription glasses? Y N

Contact Lens Wearers:

How many hours per day do you wear them? _____

How many days a week do you wear them? _____

Who fit your contact lenses? _____

What solution/care system is used? _____

Today's Examination:

Having eye or vision problems? Y N Brief description: _____

Do you use computers? Y N How many hours per day? _____

Do you drive? Y N Legally must you wear glasses to drive? Y N

Hobbies or interests: _____

PLEASE TURN PAGE OVER TO SIGN MSP AUTHORIZATION