Premier Vision Partners - Visit Information

Pt #_____

Full Name_____ Date of birth_____ Social Security #_____-____-_____

Address_____ City_____ Zip Code_____

Email_____ Employer_____

Home Phone_____ Cell _____ Marital Status S M W D

Primary physician_____

Medications *Enter all medications taken, and for which condition each is taken*

Medication **Condition**

_____

_____

_____

_____

_____

_____

_____

Allergies *Enter all medications or substances to which the patient is allergic*

_____

Eye Health *Check all that apply*

__Amblyopia

__Blurred Vision- Far or near

__Burning Eyes

__Cataracts

__Double/Distorted Vision

__Drooping Eyelid

__Dry Eyes

__Eye Surgeries

__Floaters/Spots

__Fluctuating Vision

__Foreign Body Sensation

__Glaucoma

__Glare/Light Sensitivity

__Headaches

__Itchy Feeling

__Mucus/Discharge

__Redness

__Retinal Detachment

__Teary/Watery Eyes

Do you smoke tobacco products? __Yes, I smoke every day __Yes, I smoke occasionally __No, I'm a former smoker __No, I've never been a smoker

Are you pregnant or nursing? __Yes __No

Do you wear glasses? __Yes __No

Do you have trouble driving at night? __Yes __No

Do you wear contacts? __Yes __No