Ozark Eyes

Dr. Jeff Myers & Dr. Justin Beavers

Welcome to the Office!

Today's Date _____

Last Name _____ First Name _____ MI ____ Sex M F Age_____ DOB _____

Street _____ City _____ State _____ Zip _____

(H) _____-_____-_____ (W) _____-_____-_____ (C) _____-_____-_____ Patients Social Security Number _____-_____-_____

Occupation _____ Employer (or School) _____

Spouse (or Parent's) Name _____ Spouse (or Parent's) Work _____

What is the major purpose of this visit? _____ Any problems with present contact lenses or glasses? _____

Family Medical/Eye History (Check all that apply)

		Relationship
Blindness	☐	_____
Cataracts	☐	_____
Corneal Problems	☐	_____
Glaucoma	☐	_____
Lazy Eye	☐	_____
Macular Degeneration	☐	_____
Retinal Problems	☐	_____
Diabetes	☐	_____
Heart Disease	☐	_____

Patient Medical History

Family Physician _____

Town _____ Date of Last Physical _____

Current Medications (Rx or Over the Counter)
(List name of medications including eye drops, vitamins & birth control) _____

_____

Allergies to Medications ☐ Yes ☐ No If yes, please explain:

_____

_____

Have you ever been diagnosed or treated for the following?

☐Allergies ☐Asthma ☐Arthritis
☐Cancer ☐Cholesterol ☐Diabetes
☐Heart Disease ☐High Blood Pressure ☐Kidney
☐Nerves ☐Thyroid
☐Other_____

Patient Eye History

Date of Last Eye Exam _____ By Whom? _____

Have you ever tried contact lenses? ☐ Yes ☐ No
What kind? _____

Do you currently wear contact Lenses? ☐ Yes ☐ No
What kind? _____

Solutions used _____

_____

Would you prefer clear contact lenses or colored lenses to change the color of your eyes? _____

Do you..... (Check box if answer is yes)

- ☐ Work at a computer?
- ☐ Sometimes experience dry eyes?
- ☐ Think you might benefit from thinner, lighter lenses?
- ☐ Have interest in a Test Drive of the latest in contact lens design?
- ☐ Spend time outdoors? (How much?) _____ hrs/wk
- ☐ Have prescription sunglasses?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want information on Laser Vision Correction surgery?
- ☐ Have interest in a non-surgical approach to vision correction?
- ☐ Have more than 1 pair of current Rx glasses?
- ☐ Have children?
- ☐ Have family members in need of eye care?

If you wear bifocals, are you bothered by the lines or head tilting?
☐ Yes ☐ No

If you wear contact lenses, are you satisfied with the vision and comfort? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following?

☐Cataracts ☐Corneal Abrasion ☐Eye Infection
☐Eye Injury ☐Glaucoma ☐Iritis/Uveitis
☐Lazy Eye ☐Macular Degeneration
☐Retinal Detachment ☐Other Eye Disorder

Do you experience or have you ever experienced?

☐Blurry vision ☐Burning ☐Crossed eye/eye turn
☐Double Vision ☐Flash of Light ☐Floaters/Spots
☐Grittiness ☐Headaches ☐Itchiness
☐Severe Dryness ☐Light Sensitive ☐Tearing
☐Trouble seeing at night ☐Uncomfortable glasses