Name: ______________________________

Date: ______________________

MOUNTAIN SHADOWS VISION CENTER, LLC

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

Current Occupation: ______________________ Years: ____________ Employer: __________________________

Do you use a computer? O Yes O No How many hours/day: _______ Distance from Computer: _________

Do you drive? O Yes O No Mileage to work each way: _______ Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

SPECTACLE LENS HISTORY

Do you Currently wear glasses? O Yes O No Since: ___________

Type of glasses ❑ Full Time ❑ Part Time ❑ Distance ❑ Close

Glasses Owned

❑ Single Vision ❑ Bifocals ❑ Trifocals ❑ Back-up Glasses ❑ Safety Glasses ❑ Sports Glasses ❑ Progressive

Have you had trouble in the past with glasses? O Yes O No ____

Do you wear Sunglasses? O Yes O No Are your sun glasses your current prescription? O Yes O No

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CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping: __________________________

Do you currently wear contact lenses? O Yes O No Since: ____

If not a contact lens wearer, are you interested in trying contact lenses or CRT® at this time? O Yes O No

Type and brand of contact lenses: __________________________________ Today's wearing time? ___________

How many hours/day? _________ How many days/week? ______________

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort:	_____	_____	Distance Vision:	_____	_____	Near Vision:	_____	_____

What solutions do you use? Cleaner: ____________ Disinfectant: ____________ Enzyme: _____________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Do you drink alcohol? If yes, how much/often: O No O Occasional O 1 per day O 2-3/day O 4+/day

Do you smoke? If yes, how much/often: O No O Occasional O 1 per day O 2-3/day O 4+/day

Hobbies/Interests: ____

SPECIAL EYEWEAR NEEDS

❑ Computer(special prescriptions, special anti-glare tints or coatings)

❑ Occupational (mechanics, plumbers, pilots)

❑ Safety Glasses (gardening, woodworking, welding)

❑ Sports/Hobbies (racquet sports, motorcycle)

EYE HISTORY

Headaches	O Yes	O No	Blurred Vision Distance	O Yes	O No
Glare/Light Sensitivity	O Yes	O No	Blurred Vision Near	O Yes	O No
Tired Eyes	O Yes	O No	Distorted Vision (Halos)	O Yes	O No

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Lazy Eye	O Yes	O No	Double vision	O Yes	O No
Burning	O Yes	O No	Floaters or Spots	O Yes	O No
Dryness	O Yes	O No	Fluctuating Vision	O Yes	O No
Excess Tearing/Watering	O Yes	O No	Loss of Vision	O Yes	O No
Eye Pain or Soreness	O Yes	O No	Loss of Side Vision	O Yes	O No
Foreign Body Sensation	O Yes	O No	Drooping Eyelid	O Yes	O No
Infection of Eye or Lid	O Yes	O No	Redness	O Yes	O No
Itching	O Yes	O No	Sandy or Gritty Feeling	O Yes	O No
Mucous Discharge	O Yes	O No	Crossed Eyes	O Yes	O No

GENERAL HEALTH CONDITION

Fever	O Yes	O No	Kidney	O Yes	O No
Weight Loss	O Yes	O No	Muscles, Bones, Joints	O Yes	O No
Other Constit. Symptoms	O Yes	O No	Skin	O Yes	O No
Ears, Nose, Throat	O Yes	O No	Neurological (MS)	O Yes	O No
High Blood Pressure	O Yes	O No	Anxiety, Depression, Insomnia	O Yes	O No
Respiratory (Asthma)	O Yes	O No	Diabetes, Thyroid	O Yes	O No
Gastrointestinal	O Yes	O No	Blood/Lymph (cholesterol)	O Yes	O No
Psychiatric	O Yes	O No	Allergic/Immunologic	O Yes	O No

Past Illness or Injuries: ______________________________ ______________________________

Past Surgeries: ______________________________ ______________________________

Current Medications: ______________________________ ______________________________

______________________________ ______________________________

Medicines that cause reactions or sensitivities: ____

Specific Allergies: ______________________________ ______________________________

Family History

Lazy Eye	O Yes	O No	Cancer	O Yes	O No
Blindness	O Yes	O No	Diabetes	O Yes	O No
Cataract(s)	O Yes	O No	Heart disease	O Yes	O No
Color Blindness	O Yes	O No	High Blood Pressure	O Yes	O No
Glaucoma	O Yes	O No	Kidney Disease	O Yes	O No
Macular Degeneration	O Yes	O No	Lupus	O Yes	O No
Retinal Detachment	O Yes	O No	Stroke	O Yes	O No
Eye Turn	O Yes	O No	Thyroid Disease	O Yes	O No
Arthritis	O Yes	O No	Others	O Yes	O No