Great Lakes Optometry Patient Info Check-In

Today's Date: _____ **Name:** _____ **D.O.B:** _____
Address: _____ **Phone Number:** _____ **Cell** **Landline**
City: _____ **State:** ___ **Zip:** _____ **Is it okay to text this number? Yes No**

Vision Plan: _____ Primary Card holder Name: _____
D.O.B: _____

Medical Insurance: _____ Primary Card holder Name: _____
D.O.B: _____

Primary Medical Doctor:

Medications: (We can copy a medication card instead of writing it! Just let us know!)

Allergies:

Medical Conditions your medications are for:

Eye Conditions previously diagnosed or actively managed (circle):
NONE Cataracts Glaucoma Eye turn/lazy eye Iritis/Uveitis Macular degeneration
Retinal tear/detachment Keratoconus Diabetic retinopathy Dry eye syndrome Other: _____

When was your last eye exam or eye checkup?: Where?:

Eye Surgeries:

There is a family history of (please check):
□ Cataracts □ Glaucoma □ Macular Degeneration
□ Hypertension □ Diabetes □ Cancer □ Heart Disease Other: _____

Social History (please check):
Alcohol use: □ None □ Drinks socially □ Daily
Tobacco use: □ None □ Former Smoker □ Current smoker

If you have eyeglasses, when do you use them?
All the time Reading only Digital devices only Driving Recreational activities
When not using contact lenses Other (Please Specify):

Are there any times that wearing glasses is cumbersome or not optimal?
No Yes, specify:

How much time per day do you spend on digital devices (computer, phone, tablet, etc.)?
None 1-3 Hours 4-7 Hours 8-12 Hours 12 hours or more

What is your occupation?

What are your hobbies/sports you participate in?

Does your current vision correction hinder any hobbies currently?

How did you find out about us?