



Samuelson Eyecare

Steven Samuelson O.D Lauren Ta O.D.

First Name: _____ MI: _____ Last Name: _____ Birth Date: _____

Street Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email: _____ Preferred method of contact: _____

Occupation: _____ Employer: _____ Soc. Sec. #: _____

Age: ____ Sex: ____ Marital Status (circle): Single Married Divorced Separated Widowed

Who is financially responsible for this account? _____ Relationship to Patient _____

Address of responsible party: _____ Whom may we thank for referring you: _____

Primary Care Physician: _____ In case of emergency please notify: _____

Phone: (____) _____ Last Eye Exam: _____ Dr. _____ Location: _____

Primary reason for today's appointment: _____

Have you had eye surgery: _____ what kind: _____ Date: _____

Have you had an eye injury: _____ what kind: _____ Date: _____

Please list all medications you take: _____

Allergies (Drug and/or environmental): _____

Eye Health History

Please circle "Yes" or "No" to indicate if you have had any of the following:

Blurred Vision Dist.	Yes	No	Eye Strain	Yes	No
Blurred Vision Near	Yes	No	Itchy Eyes	Yes	No
Burning Eyes	Yes	No	Light Sensitive	Yes	No
Cataracts	Yes	No	Loss of Vision	Yes	No
Double Vision	Yes	No	Red Eyes	Yes	No
Dry Eyes	Yes	No	Seeing Flashes/Floaters	Yes	No
Eye Infection	Yes	No	Watering Eyes	Yes	No

Health History

	Yourself		Family Members			Yourself		Family Members	
	Yes	No	Yes	No		Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Hepatitis	Yes	No	Yes	No
Asthma	Yes	No	Yes	No	High Blood Pressure	Yes	No	Yes	No
Blindness	Yes	No	Yes	No	Lazy Eye/Eye Turn	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Lupus	Yes	No	Yes	No
Cholesterol	Yes	No	Yes	No	Migraine Headaches	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Retinal Disease	Yes	No	Yes	No
Emphysema	Yes	No	Yes	No	Shingles	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No	Skin Conditions	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No	Sleep Apnea	Yes	No	Yes	No
Hay Fever	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Heart disease	Yes	No	Yes	No	Thyroid	Yes	No	Yes	No
Macular Degeneration	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Do you smoke?	Yes	No							

Spectacle Lens History

Do you currently wear glasses? Yes No How often: Full Time Part Time

Glasses Owned: Single Vision Bifocals Trifocals Progressive(no-line) Safety Glasses Back-up Glasses

Do you own sunglasses? Yes No Are they polarized? Yes No

Do you have trouble with night vision? Yes No Do you have trouble with glare? Yes No

Do you use a computer? Yes No How many hours per day? _____

Do you have glasses that you only use for the computer? Yes No

Please list any hobbies or recreational activities you enjoy: _____

Contact Lens History

Have you ever tried to wear contact lenses? Yes No Reason For Stopping: _____

Do you currently wear contact lenses? Yes No

Type and brand of contacts if known: Soft Rigid Single vision Mono-vision Bifocal

Brand: _____ Solution used if known: _____

Do you have to use rewetting drops? Yes No

How many hours per day do you wear your contacts? _____

How often to you wear your contacts? All the Time Part time

Do you take your contacts out at night? Yes No

Do you have a pair of back-up glasses? Yes No

Please note: there are additional fees for the contact lens evaluations. These fees are non-refundable and are **not** usually covered by insurance.

Please Print Name: _____ Date: _____

Signature of Patient, Parent or Guardian: _____