

J.M. White, O.D. & Associates, P.A.

PATIENT HISTORY AND INFORMATION

VISUAL HISTORY

Current Occupation: _____ Years _____ Employer _____

Do you use a computer? Yes No How many hours/day _____ Distance from computer _____

Do you drive? Yes No Mileage to work each way _____ Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No Do you have problems with night vision? Yes No

SPECTABLE LENS HISTORY

Do you currently wear glasses? Yes No If yes, since _____

Type of glasses: Full Time Part Time Distance Close

Glasses Owned: Single Vision Bifocals Trifocals Backup Safety Sports Progressive

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

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

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? Yes No

If yes, but not longer wearing, reason for stopping. _____

If not a contact lens wearer are you interested in trying contact lenses at this time? Yes No

Do you currently wear contact lenses? Yes No Since _____

Type and brand of contact lenses _____ Daily wearing time? _____

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

Lens Comfort:

	Right	Left		Right	Left		Right	Left
_____	_____	_____	Distance Vision:	_____	_____	Near Vision:	_____	_____

What solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

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

Do you engage in regular exercise? Yes No

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

Do you smoke? If yes, how much/often: No Occasional ½ pack/day 1 pack/day 1+ pack

Hobbies/Interests: _____

SPECIAL EYEWEAR NEEDS

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

Safety Glasses

Occupational (mechanics, plumbers, pilots)

Sports/Hobbies