Welcome to Advanced Eye Center

New Patient Adult: General Information

Full Name _____ Goes by _____

Address _____

City, State, Zip _____

Date of Birth _____ Age _____ Male _____ Female _____

Occupation _____

Home Phone _____ Cell _____ Work _____

Email _____

Spouse's Name and Occupation _____

Cell _____ Work _____

How did you hear about our center? _____

Visual History

Wear glasses for: full time use distance only near/computer only

Wear contacts for: full time use distance only monovision / multifocal

Had refractive surgery / lasik Yes No If yes, when _____

Last eye exam _____ Treatment _____

Medical History

	Patient	Family	Who
Blindness			
Cataracts			
Eye Turn / Surgery			
Glaucoma			
Macular Degeneration			
Diabetes			
High Blood Pressure			
Thyroid Condition			

Current Medications including vitamins and supplements: _____

Chief Complaint

_____ Eyewear broken

_____ Unhappy with current glasses

_____ Unhappy with current contacts

_____ Blurry Vision

_____ None

_____ Other: _____

Please check any symptoms you are experiencing:

_____ headaches
_____ fatigue
_____ short reading span
_____ print moves
_____ jerky eye movements
_____ holding material far to read
_____ slow focus recovery
_____ loss of place while reading
_____ loss of concentration
_____ poor eye-hand coordination
_____ misreads words
_____ holding material close to read
_____ covering one eye when reading
_____ head tilt
_____ color difficulties
_____ poor posture
_____ poor depth perception
_____ bumping into objects
_____ squinting
_____ glare
_____ sensitivity to light
_____ night blindness
_____ halos
_____ double vision
blurred vision at:
_____ distance
_____ computer
_____ near

Thank you for allowing us to care for your visual needs!

Dr. Jong and the staff of Advanced Eye Center