

TownCenter Vision
Patient Record

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Date of Birth: _____

Insurance Provider: _____

Family Physician: _____

Age of present glasses ? _____ Last eye exam date/ Dr.: _____

	YES	NO
Have you been to the doctors in this office before ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medication? Please List: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any medicine? What? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you or any family have Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Does sunlight or bright lights bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever see double?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an eye infection or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have color vision problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you EVER worn contact lenses in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Do you NOW wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
How old are your contacts? _____		
How many hours/day do you wear your contacts? _____		