Lifetime Vision Source

Name:_____ Preferred Language:_____

Race:_____ Ethnicity: Hispanic or Non-Hispanic

Employer:_____ Current Medical Doctor:_____

What are your expectations for today's visit?_____

Current Medications:_____

Nutritional Supplements:_____

Surgeries (last 5yrs):_____Eye Surgeries:_____

Drug Allergies:_____

Height:_____Weight:_____ Average Blood Pressure (120/75):_____/_____

Do you smoke? ☐ Yes ☐ No ☐ Previous Smoker Do You Drink Alcohol? ☐ Yes ☐ No

CURRENT EYE CONDITIONS WITH GLASSES (CHECK ALL THAT APPLY)

☐ Glaucoma	☐ Blurred at Distance	☐ Dryness	☐ Headaches
☐ Cataract	☐ Blurred at Near	☐ Tearing/Watering	☐ Floaters or Spots
☐ Macular Deg.	☐ Double Vision	☐ Redness/Burning	☐ Eye Pain
☐ Retinal Detachment	☐ Loss of Vision	☐ Itchy	☐ Foreign Body
☐ Lazy Eye	☐ Distorted Vision	☐ Sandy/Gritty Feeling	☐ Infection of Eye/Lid
☐ Drooping Eyelid		☐ Tired Eyes	☐ Glare/Light Sensitivity

CURRENT HEALTH CONDITION (CHECK ALL THAT APPLY)

☐ Ear, Nose, Throat	☐ Respiratory	☐ Neurological (e.g. MS)	☐ High Blood Pressure
☐ Gastrointestinal	☐ Anxiety, Depression	☐ Diabetes, Thyroid	☐ Kidney
☐ Cholesterol/Anemia	☐ Hay Fever, Lupus	☐ Muscle, Bones, Joints	☐ Other

FAMILY HISTORY (IMMEDIATE FAMILY)

☐ Cancer	☐ Cataracts
☐ Diabetes	☐ Macular Degeneration
☐ Hypertension	☐ Glaucoma
☐ Thyroid Disease	

HOBBIES

☐ Fishing/Hunting/Sports/Biking

☐ Sewing/Reading/Computer

☐ Mechanical/Woodworking/Gardening