LIFETIME VISION CARE, LLC

Date:_____

Name:_____

Occupation:_____

E-mail:_____

Preferred Language: ☐ English/ ☐ Spanish/ ☐ Other_____

Race: ☐ Caucasian/ ☐ Hispanic-Latino/ ☐ Other_____

Ethnicity: ☐ Non-Hispanic / ☐ Hispanic-Latino

Family Doctor:_____

Pharmacy Preference:_____

Reason For Visit:_____

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU (previous or current):

	Yes	No
General		
Cancer	☐	☐
Headache	☐	☐
Ear/ Nose/ Throat		
Sinus Condition	☐	☐
Hearing Loss	☐	☐
Dry Mouth	☐	☐
Neurologic		
Migraines	☐	☐
Epilepsy	☐	☐
Tumor	☐	☐
Stroke	☐	☐
Multiple Sclerosis	☐	☐
Cerebral Palsy	☐	☐
Psychologic		
ADD/ ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Respiratory		
Bronchitis	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

	Yes	No
Gastrointestinal (digestive)		
Colitis	☐	☐
Crohn's Disease	☐	☐
Celiac Disease	☐	☐
Musculoskeletal		
Fibromyalgia	☐	☐
Arthritis	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐
Integumentary (skin)		
Rosacea	☐	☐
Shingles (zoster)	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Cold sores (simplex)	☐	☐
Endocrinology		
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Thyroid Condition	☐	☐
Hormone Disorder	☐	☐
Blood Disorders		
Anemia	☐	☐
High Cholesterol	☐	☐
Allergic Conditions		
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogren's Syndrome	☐	☐

Females Only: Are you currently pregnant or nursing? ☐ **YES** ☐ **NO**

LIST CURRENT MEDICATIONS:

LIST MEDICATION ALLERGIES:

LATEX ALLERGY? ☐ **YES** ☐ **NO**

Do YOU have (or have you previously had) any of the following eye conditions:

☐ Cataract; ☐ Glaucoma; ☐ Macular degeneration; ☐ Other:_____

Are you a smoker? ☐ **YES** ☐ **NO** ☐ **Former Smoker**

Do you drink alcohol? ☐ **YES** ☐ **NO**

Height: _____/ Weight:_____

(For Staff Use)

Blood Pressure	Pulse	Date
_____/_____	_____	____/____/____
_____/_____	_____	____/____/____
_____/_____	_____	____/____/____
_____/_____	_____	____/____/____

PLEASE TURN OVER – COMPLETE BACK PAGE

Does a <u>member of your family</u> have any of the following conditions (list who has the condition):

Cataract:	☐ YES _____, ☐ NO	Thyroid Disease:	☐ YES _____, ☐ NO
Macular degeneration:	☐ YES _____, ☐ NO	Cancer:	☐ YES _____, ☐ NO
Glaucoma:	☐ YES _____, ☐ NO	Diabetes:	☐ YES _____, ☐ NO
Other:_____		Hypertension:	☐ YES _____, ☐ NO

Do you wear contact lenses? ☐ YES ☐ NO ☐ Never worn, but interested

If yes, what kind do you wear?

☐ Soft; ☐ Hard (Gas Perm); ☐ Toric (Astigmatism); ☐ Multifocal; ☐ Monovision (one distance, one near)

How often are they used and replaced?

☐ Daily; ☐ 2 Weeks; ☐ Monthly; ☐ 3 months; ☐ 1 year; ☐ Overnight wear; ☐ Occasional Use

What solution do you use? _____

Patient Acknowledge Review of Information & Revisions, if needed

Initials	Date
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____