



CustomEyes

Welcome back.

**Scott Drake, O.D. | Linda Drake, O.D.
Jessica Kellerman, O.D. | Julie Zybko, O.D.**

Last Name _____ Today's Date _____
First Name _____ MI _____
Street _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email Address _____

What is your occupation? _____

What is your major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

CURRENT MEDICATIONS (Rx or Over-the-Counter)

List name of medications including eye drops, vitamins and birth control pills, and what you are taking them for.

MEDICATION	REASON FOR TAKING
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to medications? Yes No

Have you been diagnosed or treated for the following?

- Cancer Cholesterol Diabetes Heart Disease
 High Blood Pressure Thyroid Disease Other _____

Has anyone in your family been diagnosed with macular degeneration? Yes No

Are you a current smoker? Yes No

Do you currently wear contact lenses? Yes No

Are you pregnant at this time? Yes No

Are you interested in longer, darker lashes? Yes No

Are you experiencing any of these symptoms?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Flash of light | <input type="checkbox"/> Sunlight sensitivity | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Tearing | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Crossed eye | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Mild, moderate or severe dryness |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Headaches | <input type="checkbox"/> Itchiness | <input type="checkbox"/> Uncomfortable eyes |

Signature _____ Date _____