****

**WELCOME TO OUR OFFICE**

**Dr. Barbra R. Johnson**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male or Female Age\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_ Employed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Eye Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age of Present Eyeglasses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ***CURRENTLY*** have any problems in the following area? If ***YES***, please provide details.

|  |  |  |  |
| --- | --- | --- | --- |
| **PROBLEM** | **YES** | **NO** | **DETAILS** |
| Double Vision |  |  |  |
| Drooping Lids |  |  |  |
| Dry Eyes |  |  |  |
| Flashes of Light |  |  |  |
| Floaters |  |  |  |
| Foreign Body Sensation |  |  |  |
| Headaches |  |  |  |
| Irritation |  |  |  |
| Itchy Eyes |  |  |  |
| Migraines |  |  |  |
| Pain |  |  |  |
| Photophobia (Light Sensitivity) |  |  |  |
| Red Eyes |  |  |  |
| Scratchy /Gritty Feeling |  |  |  |
| Swelling in Eyelid (s) |  |  |  |
| Tearing/Watery |  |  |  |
| Blurred Distant or Near Vision |  |  |  |

**Do you wear glasses now? YES NO**

**Do you wear contact lenses now? YES NO**

**Do you *WANT* contact lenses?** **YES NO (***Additional fees apply****)***

**Do you use eye drops? Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like information about LASIK?** **YES NO**