Demographics/Medical/Ocular History

Date: _____

Name_____ Age_____ Date of Birth _____

Address _____ Phone: CELL _____

City _____ State _____ Zip _____ Phone: HOME _____

Email Address_____Responsible Party (if minor) _____

Occupation/Where Employed _____

Primary reason for visit_____ Date of last exam _____

Have you ever had an eye exam or purchased glasses or contact lenses at any Costco before? _____
If Yes, which Costco location_____

Do you currently wear glasses? _____ If yes, are they used for: Distance Reading Bifocals
Do you wear contacts? _____ If yes, what type or brand name? _____

Do you experience any of the following:

Poor distance vision	Yes	No	Itching sensation of eyes	Yes	No	High blood pressure	Yes	No
Poor near vision	Yes	No	Eye pain	Yes	No	High blood sugar	Yes	No
Eye fatigue	Yes	No	Redness of eyes	Yes	No	Arthritis	Yes	No
Overly sensitive to light	Yes	No	Loss of vision	Yes	No	Allergies	Yes	No
Excess tearing of eyes	Yes	No	Headaches	Yes	No	Congestion	Yes	No

Have you ever had any Eye Disease? _____Eye Injury?_____ Eye Surgery? _____
If yes, explain _____

Past Medical History: None

Anxiety	Yes	No	Coronary Artery Disease	Yes	No	High cholesterol	Yes	No
Arthritis	Yes	No	Depression	Yes	No	Thyroid *HYPER / HYPO*	Yes	No
Asthma	Yes	No	Diabetes	Yes	No	Stroke	Yes	No
Cancer *TYPE* _____	Yes	No	Hypertension	Yes	No	Other_____	Yes	No

Family History:

Diabetes	Yes	No	Who_____	Glaucoma	Yes	No	Who_____
Heart Disease	Yes	No	Who_____	Macular Degeneration	Yes	No	Who_____

Are you taking any medication? _____ If yes, list below

Medication _____ Condition Treated _____
_____ _____

Allergies: None If yes, list _____ Smoking Status Never Former Current
_____ How Long _____

BY SIGNING BELOW, I AGREE THAT I HAVE REVIEWED, UNDERSTOOD, AND RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

Patient or Responsible Party _____ Date _____