AHLQUIST EYECARE PROFESSIONALS

Name: ____Date:_________
Occupation: ____Age:_________

Have you been to this office before? Y or N (please circle)

Do you currently wear glasses? Y or N(please circle)Are you interested in contact lenses? Y or N

List any medications you are currently take (including birth control or hormones):
____.

List any drug allergies:
____.

If female, are your pregnant or nursing? Y or N (please circle)

List any EYE injury, surgery or disease you have had:
____.

Personal Eye History- please circle Yes or No. Blood Relative and Personal History- please circle

Personal Eye History			Blood Relative and Personal History		
Headaches	Yes	No	Amblyopic (lazy eye)	self	relative
Glare/light sensitivity	Yes	No	Cataract	self	relative
Burning	Yes	No	Color Blind	self	relative
Excess tearing/watering	Yes	No	Glaucoma	self	relative
Eye pain or soreness	Yes	No	Macular Degeneration	self	relative
Itching	Yes	No	Retinal problems	self	relative
Mucous discharge	Yes	No	Strabismus (eye turn)	self	relative
Blurred distance vision	Yes	No	Arthritis	self	relative
Blurred near vision	Yes	No	Cancer	self	relative
Double vision	Yes	No	Diabetes	self	relative
Flashes or floaters	Yes	No	Heart disease	self	relative
Loss of side vision	Yes	No	Kidney disease	self	relative
			Lupus	self	relative
			Stroke	self	relative
			Thyroid	self	relative

Payments due at time services are provided. All materials must be paid in full prior to order. Payment by cash, check, credit card/CareCredit, minimum of $20.00 charge on all charge cards. Due to customization of all spectacle and contact lens orders, all sales are final.