Welcome to Clear Choice Eyecare

Patient Name: _____ (M☐F☐ Date of Birth: _____

Address: _____ City: _____State: _____Zip: _____

Home Phone: _____ Cell/Work: _____

Email Address: _____

Occupation/Hobbies relating to Eye Concerns: _____

Year of last Eye Exam: _____ Do you wear glasses? Y☐N☐

Do you wear contacts? Y☐N☐ Contact Lens Brand: _____

If yes, any concerns with current glasses and/or contacts?_____

_____

Ocular History: Allergies ☐ Cataracts ☐ Dry Eyes ☐ Glaucoma ☐
Floaters ☐ Headache/Migraine ☐ Injury ☐ Lazy Eye/Amblyopia ☐
Macular Degeneration ☐ Retinal Detachment ☐ Surgery ☐ Other_____

General Health: Diabetes_☐_High blood pressure_☐_High cholesterol_☐_

Other health conditions:_____

Current Medications:_____

Do you have any allergies to medications?_____

Family history: Diabetes ☐ Cataracts ☐ Glaucoma ☐ High Blood Pressure ☐
Macular Degeneration ☐ Retinal Detachment ☐ Other_____

HIPAA Acknowledgement(Signature): _____ Date:_____
Alternate Contact: Name:_____ Phone: _____