LIFETIME VISION CARE, LLC

Name:_____

Date:_____

Occupation:_____

Mailing Address:_____

_____

E-mail:_____

Preferred Language: □ English/ □ Spanish/ □ Other_____

Race: □ Caucasian/ □ Hispanic-Latino/ □ Other_____

Ethnicity: □ Non-Hispanic / □ Hispanic-Latino

Family Doctor:_____

Pharmacy Preference:_____

Reason For Visit:_____

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU (previous or current):

	Yes		Yes
General		**Gastrointestinal (digestive)**	
Cancer	□	Colitis	□
Headache (chronic)	□	Crohn's Disease	□
Ear/ Nose/ Throat		Celiac Disease	□
Sinus Condition	□	**Musculoskeletal**	
Hearing Loss	□	Fibromyalgia	□
Dry Mouth	□	Arthritis	□
Neurologic		Muscular Dystrophy	□
Migraines	□	Gout	□
Epilepsy	□	**Integumentary (skin)**	
Tumor	□	Rosacea	□
Stroke	□	Shingles (zoster)	□
Multiple Sclerosis	□	Psoriasis	□
Cerebral Palsy	□	Eczema	□
Parkinson's Disease	□	Cold sores (simplex)	□
Psychologic		**Endocrinology**	
ADD/ ADHD	□	Type 1 Diabetes	□
Depression	□	Type 2 Diabetes	□
Anxiety	□	Graves Disease	□
Cardiovascular		Thyroid Condition	□
Heart Disease	□	Hormone Disorder	□
High Blood Pressure	□	**Blood Disorders**	
Vascular Disease	□	Anemia	□
Respiratory		High Cholesterol	□
Bronchitis	□	**Allergic Conditions**	
Sleep Apnea	□	Lupus	□
Asthma	□	Rheumatoid Arthritis	□
Emphysema	□	Sjogren's Syndrome	□

Females Only: Are you currently pregnant or nursing? □ **YES** □ **NO**

Please turn over and complete the back of this form.

Do you have (or previously had) a concussion?: □ **YES** □ **NO** **When:_____**

Do you have (or previously had) any of the following please circle any that apply

Double Vision, Light sensitivity, Dizziness, Visual Fatigue, Balance issues, headaches,

Reading/concentration issues, Decreased spatial awareness.

LIST CURRENT MEDICATIONS:

LIST MEDICATION ALLERGIES: LATEX ALLERGY? □ YES □ NO

Do <u>YOU</u> have (or have you previously had) any of the following eye conditions:

□ Cataract; □ Glaucoma; □ Macular degeneration;

□Other:_____

Are you a smoker? □ YES □ NO □ Former Smoker □ Vape □ Other

Do you drink alcohol? □ YES □ NO

Does a <u>MEMBER OF YOUR FAMILY</u> have (or have they previously had) any of the following conditions (list who has the condition):

Cataract: □ YES _____, □ NO

Macular degeneration: □ YES _____, □ NO

Glaucoma: □ YES _____, □ NO

Other:_____

Thyroid Disease: □ YES _____, □ NO

Cancer: □ YES _____, □ NO

Diabetes: □ YES _____, □ NO

Hypertension: □ YES _____, □ NO

Do you wear contact lenses? □ **YES** □ **NO** □ **Never worn, but interested**

If yes, do you want to **renew** (expires after 1 year) your contact lens prescription today, it is separate from the comprehensive exam? □ **YES** □ **NO**

If yes, there will be a corneal health EVAL FEE (determined by the doctor) ranging from $40 to $150.

Please initial and date acknowledging this fee.

Initials	Date
_____	___/___/___
_____	___/___/___