PATIENT INFORMATION (Please Print)					
Last Name	First Name	M.I.	Male Female	Age	Birthdate
Address City State Zip Code					Home Phone ( )
Email	Have you purchased glasses/contacts from any Costco? Please circle. YES NO				Cell Phone ( )
Vision Insurance, if any: Please check ____ Spectera/ Secure Horizon/ United Health Care ____ VSP (Vision Service Plan) ____ Costco MES employee & dependents ____ Superior Vision ____ MES (Medical Eye Services) ____ Davis Vision / FED Blue Vision ____ ***No Vision Insurance/ Self-Pay***	Name of Insurance Policy Holder		SS# of Insurance Policy Holder		
	ID# of Insurance Policy Holder		Birthdate of Insurance Policy Holder		
Occupation	Employer				

1. When was your last eye exam? _____ Where? _____
2. When did you last have your eyes dilated? _____
3. Do you feel your distance vision is changing? ___NO ___ YES
4. Do you feel your near vision is changing? ___ NO ___YES
5. Please check if ***you*** have any of the following: (Please check/circle all that applies)

___ Floaters/flashes of light ___ Double vision or lazy eye ___ High blood pressure
___ Glaucoma or high eye pressure ___ Dry, burning, or watery eyes ___ Diabetes
___ Cataracts ___ Allergies with itchy eyes ___ Elevated cholesterol
___ Macular degeneration or retinal detachment ___ Thyroid condition ___ Cancer / stroke / heart disease
___ Frequent headaches related to your eyes ___ Other medical history (specify)_____

6. Please check if any ***family members*** have any of the following:

___ Glaucoma →Who_____ ___ Macular Degeneration/Retinal disease →Who_____
___ Diabetes →Who_____ ___ High Blood Pressure →Who_____
___ Thyroid →Who_____ ___Multiple Sclerosis (MS)/ Lupus →Who_____
___High Cholesterol→Who_____ ___Cancer / stroke / heart disease→Who_____
___Other family history (specify)_____

7. When was your last full medical/physical exam? _____
8. If female, are you pregnant or nursing? ___ NO ___ YES
9. Do you smoke? ___ NO ___ YES
10. Do you have sleep apnea? ___ NO ___ YES
11. Are you taking any medications and/or vitamins? ___ NO ___ YES Please list _____
12. Are you allergic to any medications or eye drops? ___ NO ___ YES Please list _____
13. Have you had any eye injury and/or eye surgery? ___NO ___YES Please list_____
14. How many hours are you on the computer/electronics per day? _____
15. Which sports or hobbies do you enjoy? (so we may know your visual needs) _____
16. Are you interested in trying contact lenses (even for occasional use)? ___ NO ___ YES ___ I currently wear them

3-D OPTOMAP RETINAL IMAGING (dilation not necessary)

Viewing the retina inside your eyes is necessary in order to ensure optimal eye health. Many eye diseases can be diagnosed early through retina imaging which otherwise may not be detected. The retinal images will become a permanent record to compare year after year. The procedure is comfortable, painless and dilation is not necessary.

The cost of having your eyes 3-D imaged is $29 (not cover by insurance).

Please Initial: _____ I ***consent*** for OptoMap Imaging.
_____ I ***decline*** to have OptoMap Imaging at this time.

I am aware that my records will not be released without my written authorization in accordance with HIPPA policies. This office is an Independent Optometry Practice. Payment is due at the time of service and is non-refundable.

_____ _____
Patient Signature (if under 18, parent signature required) Date

CONTACT LENS HISTORY (if currently wearing contacts)

17. What brand are your contacts? ___ Acuvue ___ CIBA Air Optics ___ Bausch & Lomb ___ Freshlook ___ Other
18. If applicable, which *specialty* fit contact lenses worn: ___ Astigmatism/Toric ___ Monovision ___ Multifocal Soft Lens ___ Rigid Gas Perm/Hard Contact Lens
19. Do you sleep with your contact lenses? ___ NO ___ YES How many days per week? _____
20. How often do you replace your contacts? _____ How old are your current contacts? _____
21. What lens care system do you use? ___ Opti-Free ___ ReNu ___ ClearCare ___ Other _____