TSO
WESTLAKE

Personal Information

Name: _____ Date Of Birth: _____

Address: _____ Primary Phone: _____

_____ Secondary Phone: _____

City: _____ State: _____ Zip Code: _____ Preferred Contact [ ]

Email Address: _____ Are you nursing or pregnant? ◯ No ◯ Yes

Do you participate in an activity that may require eye protection? (list) : _____

Medical Review

What is the reason for today's exam? _____

When was your last eye exam? _____

What do you primarily use to correct your vision? ◯ Glasses ◯ Contacts

	Yes	No	
Do you wear glasses?	◯	◯	If yes, for... ☐ Reading ☐ Computer ☐ Full Time
Do you wear contacts?	◯	◯	If yes, what type? _____
Do you take eye drops?	◯	◯	If yes, what type? _____
Would you like to try contacts?	◯	◯	
Would you like laser vision correction?	◯	◯	

Please check any symptoms you may be experiencing:

☐ Blurred Vision	☐ Glare	☐ Tearing/Watering	☐ Light Sensitivity
☐ Discharge	☐ Red Eyes	☐ Eye Injury	☐ Eyestrain
☐ Eye Pain	☐ Distorted Vision	☐ Double Vision	☐ Loss of vision
☐ Dryness	☐ Burning	☐ Irritation	☐ Difficulty driving at night
☐ Sties/Chalazion	☐ Eyestrain (PC)	☐ Fluctuating Vision	☐ Loss of side vision
☐ Flashes of Light	☐ Sandy/Gritty	☐ Floating Spots	☐ Foreign object sensation
☐ Itching	☐ Chronic infection of eye or lid	☐ Other: _____	

Insurance

Please hand your insurance cards to the front desk, or please fill out the following information.

Do you have Vision Insurance ◯ Yes ◯ No If yes, which provider? _____

Insurance Member ID: _____ Group Number: _____

Name of primary holder & DOB _____

Do you have Medical Insurance ◯ Yes ◯ No If yes, which provider? _____

Insurance Member ID: _____ Group Number: _____

Name of primary holder & DOB _____

Medical Review of family history

Please indicate any condition that applies to you or a family member:

	Who?		Who?
Diabetes		Retinal Detachment	
High Blood Pressure		Eye Surgery	
Cancer		Lazy Eye	
Heart Problems		Double Vision	
Respiratory Problems		Blindness	
Thyroid Problems		Loss of Vision	
Headaches		Glaucoma	
Stroke		Macular Degeneration	
Head/Eye injury		Cataracts	

Medications & Allergies

Please list all medications you are currently taking (including birth control, vitamins, and herbs):

Are you allergic to any medications? ◯ No ◯ Yes If yes, what?

Do you have general/seasonal allergies? ◯ No ◯ Yes If yes, what?

Do you use tobacco products? ◯ No ◯ Yes Do you use alcohol? ◯ No ◯ Yes

Employment

Employer: Occupation:

School (Student): Grade Level:

How did you find our office?

◯ Yellow Pages ◯ Location ◯ Radio ◯ Family Doctor ◯ Insurance Plan

◯ Newspaper ◯ Television ◯ Mail Out ◯ Referred by :

Submit by E-mail