Welcome back to Springboro Vision Center

Patient Information (Please print) If any personal information (i.e. address, phone number, insurance, marital status, etc.) has changed since your last visit, please notify our receptionist.

Vision Lifestyle

Name_____Age_____ Current Grade/School_____
Occupation _____Employer_____
Hobbies _____Do you use a computer?_____ How many hours/day_____

Medical History

Name of family physician & city _____Last physical exam?_____
Please list any medical conditions you are currently being treated for_____
_____
Please list your past experiences with illnesses, operations, injuries and treatments_____
_____
_____
Please list any family medical events or diseases which may be hereditary or put you at risk_____
_____
Please list all medications you are currently taking (include birth control, hormone, non-prescription & eye drops)
_____
_____
Do you currently use: alcohol _____ tobacco products_____ drugs_____
Please list any medications you are allergic to_____

Do you or any close blood relatives have problems in any of the following body systems or conditions?

	Self		Family			Self		Family	
	Y	N	Y	N		Y	N	Y	N
Constitutional symptoms i.e. fever, weight loss	☐	☐	☐	☐	Musculoskeletal	☐	☐	☐	☐
					Integumentary	☐	☐	☐	☐
Ears, nose, mouth, throat	☐	☐	☐	☐	Neurologic	☐	☐	☐	☐
Cardiovascular	☐	☐	☐	☐	Psychiatric	☐	☐	☐	☐
Respiratory	☐	☐	☐	☐	Endocrine	☐	☐	☐	☐
Gastrointestinal	☐	☐	☐	☐	Blood/lymph	☐	☐	☐	☐
Genitourinary	☐	☐	☐	☐	Allergic/immunologic	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Cancer	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Sinus infections	☐	☐	☐	☐
EYES									
Turned or lazy eye	☐	☐	☐	☐	Glaucoma	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	Eye surgery	☐	☐	☐	☐
Eye injury	☐	☐	☐	☐	Tearing, itching	☐	☐	☐	☐
Floaters	☐	☐	☐	☐	Flashes	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Loss of vision	☐	☐	☐	☐
Styes	☐	☐	☐	☐	Eye infections	☐	☐	☐	☐

Contact Lens History

☐ Never worn contacts ☐ Not interested in contacts ☐ Would like to know my contact lens options

Please check the type of contact lens you currently wear

☐ Daily wear soft lenses ☐ Extended wear soft lenses ☐ Astigmatism soft lenses ☐ Rigid gas permeable
☐ Planned replacement ☐ Disposable ☐ Bifocal contacts ☐ Monovision (one eye for reading)

How many hours per day do you wear your contacts? _____ How old are your current contacts? _____
What brand of contact lens solutions do you currently use? _____
Are you allergic to any brand of solutions? _____
Please list any problems you have with your current contact lenses. _____
_____