Dr. Jason L Bradley Optometrist

# EXAMINATION FORM

## Patient Information

Last Name_____ First_____ MI _____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell_____ Work_____

Birth Date_____ Occupation_____

## Patient History

1. What is your main reason for today's exam? _____

2. Date of last eye exam_____ from Dr. _____

3. Do you work with a computer? ☐No ☐Yes If yes, how many hours per day?_____

4. Have you ever had an eye infection, disease, injury, or surgery?
☐No ☐Yes Please list_____

5. Are you taking any medications?
☐No ☐ Yes Please list_____

6. Are you allergic to any medications?
☐ No ☐ Yes Please list_____

7. Do you or any blood relatives have diabetes? ☐ No ☐Yes Who? _____

high blood pressure? ☐ No ☐Yes Who? _____

thyroid problems? ☐ No ☐Yes Who? _____

glaucoma? ☐ No ☐Yes Who? _____

macular degeneration? ☐ No ☐Yes Who? _____

retinal detachment? ☐ No ☐Yes Who? _____

## Contact Lens History

8. Have you ever worn contact lenses? ☐ No ☐ Yes

9. Do you now wear contact lenses? ☐ No ☐ Yes

10. What solution do you use? _____

11. Are you interested in new contact lenses? ☐ No ☐ Yes

## Vision Insurance

12. Do you have vision insurance? ☐ No ☐ Yes

Provider_____ Policy Number_____