JEMS OPTICAL, LLC

Name _____ **Date** _____

Address _____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____

Cell Phone_____ **Email** _____

Date of Birth _____ **Vision Insurance**_____

Health Insurance_____

Occupation_____ **Employer**_____

Name of Previous eye doctor _____

How did you find out about our office?_____

Who may we thank for referring you? _____

When was your last eye examination? _____

Do you wear glasses?_____ **Have you worn glasses in the past?**_____

Do you wear contact lenses? _____ **What type? (Circle all that apply)**

Soft Gas Permeable Hard Daily Wear Overnight Wear Disposable

If you no longer wear contact lenses, why did you stop? _____

Have you ever had an: Eye Injury? _____ **Eye Infection?** _____ **Eye Surgery?** _____

Do you, or any family member have: High Blood Pressure? _____ **Diabetes?** _____

Glaucoma? _____ **Macular Degeneration?** _____ **Other Eye Diseases?** _____

Do you have any general health problems? _____

List all medications you are taking (prescription and OTC, including birth control) _____

_____

List all allergies (drug and/or environmental) _____

_____

What is the reason for today's visit? _____

_____