M. A. Shurtz, O.D. & Associates, PLLC.

PATIENT HISTORY AND INFORMATION

☐	American Indian or Alaska Native	☐	Native Hawaiian or Pacific Islander	Height feet	inches
☐	Asian	☐	White	Weight lbs	
☐	Black or African American	☐	Declined To State	Preferred Language	
☐	Hispanic or Latino	☐	Other	Ethnicity	

VISUAL HISTORY

Current Occupation: _____ Years _____ Employer _____

Do you use a computer? ☐ Yes ☐ No How many hours/day _____ Distance from computer _____inches

Do you drive? ☐ Yes ☐ No Mileage to work each way _____ Do you have glare problems? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No Do you have problems with night vision? ☐ Yes ☐ No

SPECTACLE LENS HISTORY

Do you currently wear glasses? ☐ Yes ☐ No If yes, since _____

How often do you wear glasses: ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Type of glasses: ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ☐ Yes ☐ No _____

Do you wear sunglasses? ☐ Yes ☐ No Are your sun glasses your current prescription? ☐ Yes ☐ No

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

If yes, but no longer wearing, reason for stopping. _____

If not a contact lens wearer are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No Since _____

Type and brand of contact lenses _____ Daily wearing time? _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort:	_____	_____	Distance Vision:	_____	_____	Near Vision:	_____	_____

What solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SOCIAL HISTORY

Do you use vitamins or supplements? ☐ Yes ☐ No Do you engage in regular exercise? ☐ Yes ☐ No

Do you drink alcohol? If yes, how much/often: ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3/day ☐ 4+/day

Do you smoke? If yes, how much/often: ☐ No ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack

Hobbies/Interests: _____

SPECIAL EYEWEAR NEEDS

☐ Computer ☐ Safety Glasses ☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies