Welcome to ProView Eye Care! We are excited to welcome you as a new patient and thank you for choosing us for your vision and eye health needs.

To get started, we would like to learn more about you and your eyes. The following is a checklist of what the doctor will need to provide you with the best possible care.

◯ **Completed Welcome Form**

◯ **Completed Lifestyle Questionnaire**

◯ **Insurance cards or claim forms:** We require your medical insurance card to address any medically related eye conditions.

◯ **Prescription eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or nonprescription reading glasses, sunglasses, etc. This will help us to determine any change in your prescription.

◯ **Contact Lenses:** Please bring your contact lens box or packets that indicate the lens series, power, manufacture, etc. This will give us an idea of your current lenses and how we may make any improvements, if any desired.

◯ **Eye drops, ointments, etc.:** Please bring any eye drops and/or ointments you are currently using. Your doctor will review these and may suggests any alternatives if necessary.

We appreciate you taking the time to provide us with this information. These items will help the doctor in providing you with a comprehensive and thorough vision and eye health examination.

Please contact us if you have any questions or concerns. We look forward to seeing you!

ProView Eye Care
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PROVIEW
EYE CARE OPTOMETRY
See Better | Look Better | Feel Better

Patient Information

◯ Dr. ◯ Mr. ◯ Ms. ◯ Mrs. Name_____Date_____

Date of birth_____Age_____Gender: ◯ Male ◯ Female

Address_____City_____State_____Zip_____

Home phone_____Mobile phone_____Text messaging ok? ◯ Yes ◯ No

Email_____Occupation_____

**Primary reason for today's visit:*_____

**Any problems with your current glasses and/or contact lenses?*_____

_____

**How did you hear about us?* ◯ *Social Media* ◯ *Insurance* ◯ *Family/friend, who?*_____

◯ *Doctor referral* ◯ *Other:*_____

Patient Medical History

Name of family physician_____

Date of last physical check up_____

Medical insurance_____

◯ HMO ◯ PPO ◯ I do not have medical insurance

Current medical illnesses:_____

_____

_____

Current medications (including eye drops):

_____

_____

Allergies to medications? ◯ Yes (list below) ◯ No

_____

_____

Patient Ocular History

Name of last eye doctor_____

Date of last eye exam_____

Any eye surgery or injury? ◯ Yes (list below) ◯ No

_____

_____

Check all that apply:

Disease/Condition	Self	Family	Relationship to you
Blindness	◯	◯	
Cataract	◯	◯	
Lazy eye	◯	◯	
Glaucoma	◯	◯	
Macular Degeneration	◯	◯	
Retinal Detachment	◯	◯	
Diabetes	◯	◯	
High Blood Pressure	◯	◯	
Lupus	◯	◯	
Rheumatoid Arthritis	◯	◯	
Cancer	◯	◯	

LIFESTYLE QUESTIONNAIRE

Patient name_____**Age**_____**Occupation**_____

This questionnaire is designed to assist your eye doctor in prescribing what best fits your visual needs and lifestyle. Please take a few moments to answer the following questions.

How many hours a day do you spend on the following:

Computer_____Smart phone_____TV_____Driving_____Digital devices_____

What outdoor activities are you involved in: (Check all that apply)

◯ Fishing ◯ Hiking ◯ Hunting ◯ Skiing ◯ Boating

◯ Traveling ◯ Garden/Yardwork ◯ Watersports ◯ Other:_____

What indoor activities are you involved in: (Check all that apply)

◯ Reading ◯ TV ◯ Computer ◯ Reading ◯ Video gaming

◯ Painting ◯ Crafting ◯ Knitting ◯Other:_____

What sport activities are you involved in: (Check all that apply)

◯ Basketball ◯ Football ◯ Baseball ◯ Tennis ◯ Golf

◯ Running ◯ Swimming ◯ Soccer ◯ Hockey ◯ Racquetball

◯ Martial Arts ◯ Other:_____

Are you interested in LASIK? ◯ No ◯ Yes

Do you currently wear glasses? ◯ No ◯ Yes, What do you use them for?_____

Do you currently wear sunglasses? ◯ No ◯ Yes

Do you have more than one pair of prescription eyewear? ◯ No ◯ Yes (Check all that apply)

◯ Everyday ◯ Computer ◯ Driving ◯ Sunwear ◯ Sports

◯ Other:_____

What is important to you? (Check all that apply)

◯ Comfort ◯ Optimized Vision ◯ Glare reduction ◯ Current lens technology

◯ Style/Updating look ◯ Eye disease prevention ◯ Backup Pair ◯ Light-weight glasses

Do you wear contact lenses? ◯ No ◯ Yes

Are you interested in contact lenses? ◯ No ◯ Yes

Which of the following would you like to improve in your contact lens wear?

◯ Vision ◯ Comfort throughout the day ◯ Comfort at the end of the day ◯ Dryness

◯ Easier cleaning and storage ◯ Longer wear time ◯ Other:_____