Lambaria Eyecare Associates

Glasses Contacts Medical

Patient Information

Patient Name:_____ Birth Date:____/____/____ Date: ____/____/_____

Address:_____ City:_____State:_____Zip:_____

Cell Phone:_____ Home:_____

Employer:_____Occupation:_____SS#:_____

Referred by:_____ E-mail:_____

Medical History

Medical Dr:_____ Last Physical: ____/____/____ Dr Phone:_____

List of medications *and dosages* you are taking:_____

_____

List medications you are allergic to:_____

Describe the allergic reaction you have:_____

The Health Care Reform Act requires the following questions to be asked:

Do you drink alcohol? ○ Yes ○ No Amount_____ Height:_____

Do you smoke? ○ Yes, current smoker ○ No, never ○ Previous smoker Weight:_____

Do you or your family members have any of the following? If yes, who?

- ○ Diabetes (Type 1) _____
- ○ Diabetes (Type 2) _____
- ○ Hypertension _____
- ○ Hyperthyroidism _____
- ○ Hypothyroidism _____
- ○ Cataract _____
- ○ Degenerative disorder of macula _____
- ○ Glaucoma_____

Dr. Lambaria will review your answers to the following? If yes, who?

Last Exam ____/____/_____ From Dr. _____ Age of glasses_____ Age of sunglasses_____

Do you participate in any of the following activities regularly?:

○ Walking/Running ○ Bicycling ○ Golfing ○ Fishing ○ Motorcycle ○ Shooting/Hunting ○ Gardening ○ Sewing ○ Automotive

Do you spend 4 or more hours a day on a computer?_____

How many hours a day do you spend using you cell phone/device?_____

How many hours a day do you spend reading/studying?_____

How many hours do you spend driving and outdoors a week?_____

Do you have a current pair of sunglasses to protect your eyes? ○ Yes ○ No

Does glare bother you? ○ Yes ○ No If Yes: During the day ○ Yes ○ No ○ At night time? ○ Yes ○ No

Are you light sensitive? ○ Yes ○ No

Are you interested in contact lenses? ○ Yes ○ No

Have you been told you cannot wear contact lenses? ○ Yes ○ No

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If you wear contacts, do you have a current pair of back up glasses? ○ Yes ○ No