VISION SOURCE®

NAME:_____ **DOB:**____/____/_____**DATE:**_____

Section 1

Are you coming in for your annual eye health and wellness visit to update your eyeglass and/or contact lens prescription?

Yes (If you've circled yes, please move on to Section 3) | No (Please complete Sections 2 & 3)

Section 2

What is the purpose for your visit? _____

_____

Which eye is affected? Right | Left | Both

When did the symptoms start? _____

What is the severity of the symptoms? Mild | Moderate | Severe

When do you notice these symptoms?_____

What makes the symptoms better? _____

What makes the symptoms worse? _____

Section 3

What health/medical conditions have you been diagnosed with? Please list here:_____

_____

_____

What prescription medications are you taking currently? (Please bring a list if necessary.)

_____

_____

If you are taking any over-the-counter medicines or vitamins, please list here:_____

_____

If you have any allergies to any medications, please list them here: _____

_____

Do you currently wear glasses and/or contacts to improve your eyesight? Yes | No

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