Welcome to **InSight Optometry & Occupational Therapy**

All information is kept strictly confidential and will only be used to provide you with the best vision care possible.

Today's Date: _____ Name: _____
Date of Birth: _____ Occupation: _____
Email Address: _____
How did you hear about our office? _____

Health & Eye History

Who is your family physician? Name: _____ City: _____
Do you have any health problems? ☐Y ☐N Brief description: _____
Do eye problems run in the family? ☐Y ☐N Brief description: _____
Do you take medication(s)? ☐Y☐N Please list: _____
Do you have any allergies? ☐Y☐N Please list: _____
Have you ever had eye injury, surgery or disease? ☐Y ☐N Brief description:
_____
Are you pregnant? ☐Y ☐N How many months? _____
Do you take birth control pills? ☐Y ☐N Name: _____

Last Eye Examination:

Date: _____
Doctor: _____ City: _____
Do you wear/have you ever worn prescription glasses? ☐Y ☐N

Contact Lens Wearers:

How many hours per day do you wear them? _____
How many days a week do you wear them? _____
Who fit your contact lenses? _____
What solution/care system is used? _____

Today's Examination:

Having eye or vision problems? ☐Y ☐N Brief description: _____
Do you use computers? ☐Y ☐N How many hours per day? _____
Do you drive? ☐Y ☐N Legally must you wear glasses to drive? ☐Y ☐N
Hobbies or interests: _____

PLEASE TURN PAGE OVER TO SIGN MSP AUTHORIZATION