WESTHAMPTON BEACH FAMILY EYE CARE
A Professional Service Limited Liability Company

Dr. Bari Miller
Optometrist

33 Sunset Avenue
Westhampton Beach, NY 11978

Telephone: 631-288-8018

Dear Patient:

Thank you for selecting **Westhampton Beach Family Eye Care**. Please fill out this form, so that we may better serve you.

Name:_______________________________ Date:_____________________________________

Address:_____________________________ Telephone:________________________________

_____________________________ Date of Birth:_____________________________

E-mail Address:____

CASE HISTORY

When was your last eye exam?____

Do you wear glasses? Yes No N/A

For distance vision? Yes No

For near vision? Yes No

Is your distance vision blurry with your glasses? Yes No

Do your eyes tire when you are reading with your glasses Yes No

Do you wear contact lenses? Yes No N/A

What type? soft lenses hard lenses disposable lenses

Brand?____

How often do you replace them?____

Is your distance vision blurry with your contact lenses? Yes No

Is your near vision blurry with your? Yes No

Do you get headaches? Yes No

EYE HISTORY

Do your eyes: itch burn water

Do you see flashes of light or floaters? Yes No Which eye? Right Left

Are you sensitive to light? Yes No

(Please complete other side of this form)

Do you have difficulty driving at night? Yes No

Do you have a lazy eye? Yes No Which eye? Right Left

Do you get double vision? Yes No

Do you have any of these symptoms when you are using a computer:

headaches burning eyes double vision tired eyes

Are you being treated for any eye problems? If yes what?____________________________

Are you using eye drops? Yes No If yes, what kind?_________________

Have you ever had an eye injury? Yes No If yes, what kind?_________________

Do you or your parents or siblings have any eye diseases such as:

Cataracts macula degeneration glaucoma retinal detachment

blindness other____

MEDICAL HISTORY

Are you taking any medications, including oral contraceptives, aspirin, O T C medications, vitamins or supplements?

Do you have any allergies to medications? List.______________________________

Do you have any medical problems such as:

Diabetes hypertension stroke heart problems asthma

Arthritis thyroid disease bleeding disorder psychiatric problems

Are you pregnant now? Yes No

SOCIAL HISTORY

Do you smoke? Yes No

Do you consume two or more alcoholic drinks a day? Yes No

What is your occupation?____

What are your hobbies?____

Do you participate in sports? Yes No Which one(s)?_______________________

Do you spend time on or near the water? Yes No

Signature:____ Date:__________________________