Date:______________

WELCOME TO GATTI VISION

Patient and Contact Information

Name____ Preferred Name________________________

Date of Birth __________________ Age _________ Gender: male/female/other

Height_________________ Weight___________________

Cell Phone ____ May we leave a message? yes/no

Alternate Number __________________________________

Email Address _____________________________________ May we email you? yes/no

Address ____

SSN _______-______-______

Employer (or School) ______________________________ Occupation (or Grade) __________________

Emergency Contact ____

Eye History and Lifestyle Questions

Date of Last Eye Exam _______________________________ By Whom? ___________________________

Are you interested in glasses, contacts or both? ❑ Glasses ❑ Contact Lenses

Do you currently wear glasses? ❑ Yes ❑ No

Age of first pair: _________________

Are you satisfied with comfort/vision? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

Brand/type: _____________________

Solutions used: __________________

Are you satisfied with the comfort/vision? ❑ Yes ❑ No

Do you prefer clear or colored lenses? ❑ Clear ❑ Colored ❑ Unsure

Have you ever experienced, been diagnosed with or treated for any of the following?

❑ Blurry Vision ❑ Burning ❑ Cataracts ❑ Corneal Abrasions

❑ Crossed eye/Eye turn ❑ Double Vision ❑ Eye Infections ❑ Eye Injury

❑ Flash of light ❑ Floaters/Spots ❑ Glaucoma ❑ Grittiness

❑ Headaches ❑ Iritis/Uveitis ❑ Itchiness ❑ Lazy Eye

❑ Macular Degeneration ❑ Occasional dryness ❑ Retinal Detachment ❑ Tearing

❑ Sunlight Sensitivity ❑ Trouble seeing at night ❑ Uncomfortable glasses

❑ Other eye disorders____

Do you have any concerns regarding your vision or health of eyes at this time? ❑ Yes ❑ No

If yes, please explain: ____

Do you… (please check boxes that apply):

❑…work at a computer? If so, how many hours per day?___

❑…have interest in the latest contact lens designs

❑…have prescription sunwear?

❑…want information on Laser Vision Correction surgery?

❑…have family members in need of eyecare?

❑…have interest in a non-surgical approach to vision correction?

❑…think you might benefit from lighter lenses?

❑…spend time outdoors? If so, ____hrs/week

❑…have more than 1 pair of current Rx eyewear?

❑…have children?

Patient Medical History

Name of family physician________________________________City________________________

Date of last physical check up__________________

Current medications (Rx or over the counter) List name of medication including *eye drops, vitamins and birth control pills*____

____

**We can photocopy your list of medications if you have them*

Allergies to medications? ❑ Yes ❑ No If so, what medications?_______________________________

Have you had any surgeries ❑ Yes ❑ No If so, what?_______________________________________

Do you use ANY tobacco products, alcohol or other substances? ❑ Yes ❑ No If so, what?_____________

Have you ever been diagnosed or treated for the following health problems?

Allergies	❑ Yes ❑ No		
Bronchitis	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Cholesterol	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Digestion	❑ Yes ❑ No	Ear/Nose/Throat	❑ Yes ❑ No
Endocrine	❑ Yes ❑ No	Eczema/Rashes	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No	Fevers	❑ Yes ❑ No
Genitourinary	❑ Yes ❑ No	High/Low Blood Pressure	❑ Yes ❑ No
Skin	❑ Yes ❑ No	Kidney	❑ Yes ❑ No
Muscle/Bone	❑ Yes ❑ No	Neurological	❑ Yes ❑ No
Psychological	❑ Yes ❑ No	Respiratory	❑ Yes ❑ No
Sinus	❑ Yes ❑ No	Weight loss/gain	❑ Yes ❑ No

Other: ____

Family Eye and Medical History

Is there a family history of the following? (please check if yes)

		Relationship:
Diabetes	❑	______________________________
Heart Disease	❑	______________________________
Cancer	❑	______________________________
Blindness	❑	______________________________
Cataracts	❑	______________________________
Glaucoma	❑	______________________________
Lazy eye	❑	______________________________
Macular degeneration	❑	______________________________

Do you agree to be dilated today to have the health of your eyes thoroughly examined by Dr. Dunn?

❑ Yes ❑ Unsure, I would like to talk to the doctor about it

The information I have provided, to the best of my knowledge, is accurate______________________________

Patient or guardian signature

Doctor Reviewed ________________________