

PATIENT PROFILE (Please Print)

DATE:
OFFICE:
OPTOMETRIST: Dr Dwight L. Bostwick, OD

Name:	Home Phone:	Work Phone:
Address:	Birthdate:	Occupation:
City:	State:	Zip:
Date of Last Exam:	Location of Last Exam:	How did you hear about us?:
Employer:	Insurance Carrier:	Group No.:
Drivers License #:	Primary Insured ID#:	

Reason for Today's Exam:

What type of exam are you here for? Glasses Contacts Both

Do you presently wear glasses? Yes No Do you wear contact lenses now? Yes No

Have you ever worn contact lenses? Yes No Are you sensitive to light? Yes No

Are you interested in trying contact lenses? Yes No

Are you having problems with your present eyewear? Yes No

What type of work do you do? _____

How many hours a day do you spend at a computer terminal? _____

Hobbies, Interests, or Sports? _____

	Yes	No
Do you have any medical problems? Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any medication? List: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies? List: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever see double? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you or any family member have Diabetes? Who? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you or any family member have Glaucoma? Who? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you or any family member have Cataracts? Who? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you or any family member have Macular Degeneration? Who? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does any family member have an eye disease? Who? _____	<input type="checkbox"/>	<input type="checkbox"/>
Describe: _____		
Have you ever had any eye disease, eye injury, or eye surgery? _____	<input type="checkbox"/>	<input type="checkbox"/>
Describe: _____		