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:____________________	☐	☐
Do you take any medication? List:____________________	☐	☐
Do you have any allergies? List:____________________	☐	☐
Do you have frequent headaches?____________________	☐	☐
Do you ever see double?____________________	☐	☐
Do you or any family member have Diabetes? Who?____________________	☐	☐
Do you or any family member have Glaucoma? Who?____________________	☐	☐
Do you or any family member have Cataracts? Who?____________________	☐	☐
Do you or any family member have Macular Degeneration? Who?____________________	☐	☐
Does any family member have an eye disease? Who?____________________	☐	☐
Describe:____________________		
Have you ever had any eye disease, eye injury, or eye surgery?____________________	☐	☐
Describe:____________________		