**Dr. Angela Lee, O.D.**

**1005 Powers Place**

**Alpharetta, GA. 30009**

**770-772-9852**

Patient Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If mobile phone, do you want to receive text messages about your optometric services?

( ) I Do ( ) I Do Not

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_Zip:\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been examined by our office before? ( ) Yes ( ) No

Reason for current visit:

( ) General Check-up ( ) Blurry Far vision ( ) Problems with current contacts

( ) Lost/broken glasses ( ) Blurry near vision ( ) Headaches

( ) Want Contact lenses ( ) Eyes burn or itch ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies to medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any eye surgery(s) or eye injury(s)? If yes,

(list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have: ( ) Diabetes ( ) Cataracts ( ) Arthritis

( ) High BP ( ) Glaucoma ( ) Heart Disease

Do any family members have: ( ) Diabetes ( ) Cataracts ( ) Arthritis

( ) High BP ( ) Glaucoma ( ) Heart Disease

Do you now wear contact lenses? ( ) Yes ( ) No If yes, brand name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: ( ) Daily ( ) Toric/Astig ( ) Rigid Gas Perm

( ) Hard ( ) Disposable ( ) Extended

\*\**We may need to instill drops to examine the eyes. These drops may cause temporary sensitivity to light and blurred near vision.*

**( ) I Do ( ) I Do Not give permission to dilate my eyes.**

***\*\*There are NO refunds for Eye Exams/Contact lenses\*\****

*Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_*