Peninsula Eye Care, LLC – Optometry & Optical

Date: __________

Last name ______________ **First name** ______________ **MI** ____

DOB ___________ **Gender** ___________ **SSN** ________-______-___________
Home Ph (___)_______________ **Work Ph** (___)_______________ **Cell** (___)_______________
Street Address ____________________________ **Apt** __________________
City, State, Zip ____________________________

Email____

Preferred language _______________________ **Race** ______________

Ethnicity __________________

Primary Care Physician __________________ **Phone #** (___)_____-____________

Whom may we thank for referring you?

Personal Eye Information

When was your last eye exam? ____________________ Do you wear glasses? **Y N** Contacts? **Y N**

Are you interested in being fit with contacts today? **Y N**

Have you ever had an eye injury or surgery? **Y N** Describe
____

Do you have (Please circle all that apply)

Dry eyes Double vision Flashes/Floaters Light sensitivity Blurred vision itching

Redness Eye pain Mucous discharge Excess tearing Loss of vision

Please tell us which activities you participate in on a regular basis (circle all that apply)

Sports: Baseball Soccer Basketball Golf Cycling Boating Running Marksmanship

CrossFit Weigh-lifting Other__________________

Crafts/hobbies: Needlework/sewing Woodworking Models Other

Occupation __________________ **Computer Use** __________**hours per day**