

Welcome to Dr. Teles' Office and Looking Glass Optical

To better serve your visual needs, it is important we understand your health and vision history and a bit about your lifestyle. Please fill in the form as completely as possible. You may bring it in with you, email it to info@lookingglassoptical.com or fax it to 410-768-1330.

Name _____ Date _____/_____/_____

Address _____ City/ State/ Zip _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Social Security Number _____ Employed By: _____

Birthday _____/_____/_____ Age _____ Approximate date of last exam? _____/_____/_____

e-mail _____ @ _____

Are You? Minor Married Divorced Widowed Single Separated (please circle one)

Spouse or Parent's Name _____ Phone Number: (_____) _____

Name of Responsible Party _____ Relationship _____

Who may we thank for referring you to us? _____

Insurance Information (Your health insurance may cover many eye disorders including dry eye and allergies.)

Vision Insurance _____ Health Insurance _____

Name of Insured _____ Relationship to Patient _____

Insured's SS# _____ Insured's Birthday _____/_____/_____

Employer _____

Your reason(s) for visiting our office: (please check appropriate items)

- | | | |
|---|---------------------------------------|---|
| <input type="radio"/> General check-up | <input type="radio"/> Eyes feel dry | <input type="radio"/> Pain in eyes |
| <input type="radio"/> Blurred near vision | <input type="radio"/> Eyes feel tired | <input type="radio"/> Light flashes or moving spots |
| <input type="radio"/> Blurred distance vision | <input type="radio"/> Eyes itch | <input type="radio"/> Contact lens check up |
| <input type="radio"/> Lost or broken glasses | <input type="radio"/> Eyes water | <input type="radio"/> Problems with contacts |
| <input type="radio"/> Double vision | <input type="radio"/> Glare | <input type="radio"/> _____ |
| <input type="radio"/> Eyes burn | <input type="radio"/> Headaches | <input type="radio"/> _____ |

Interested in contact lenses...

- | | | |
|---|-------------------------------------|---|
| <input type="radio"/> bifocal contacts | <input type="radio"/> extended wear | <input type="radio"/> "Synergeyes" (hybrid) |
| <input type="radio"/> disposable contacts | <input type="radio"/> gas permeable | <input type="radio"/> astigmatism |
| <input type="radio"/> Other (please list) _____ | | |

- I am interested in **Freedom From My Glasses and Daytime Contact Lenses** and would like to talk to Dr. Teles about my options **without** the use of Laser Surgery.
- I am interested in **Laser Vision Correction** and would like to talk to Dr. Teles about options for Laser Surgery.

All information found in this form will remain strictly confidential!

Your General and Ocular Health: Past, Present or Family

Are you presently taking any medications? Hormones, birth control pills, etc? Please state what medication(s)

Are you allergic to any medication(s)? Which ones? _____

Do you smoke? __Yes __No If yes how many packs a day? _____

Do you use alcohol? __Yes__No How often or how much? _____

Do you suffer from any of the conditions below? If so please check the appropriate items.

- | | | |
|---|--|---|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Strabismus | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Eye injuries | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Dry eye | <input type="checkbox"/> Allergies | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Retinal Disorders | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Other (please list) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Muscular-Skeletal | |
| | <input type="checkbox"/> Arthritis | |

Has anyone in your family (blood relatives) had any of the above conditions? Yes No

If so, what relative and what condition(s)? Relative: _____

(please place a * next to the condition above if a relative has had)

Does any one in your family wear glasses? Yes No **Please list members :** _____

Computer, Recreational & Occupational Vision

Have you ever worn glasses? Yes No **If so, how are they used?** Distance Near Constant

Do you use a computer more than two hours per day? Yes No

Your monitor is approximately at what viewing angle ? (Did you know that eye fatigue can occur if your monitor isn't ergonomically positioned?)

- 15° above center even with your face 15° below center

If you use your computer more than two hours per day do you experience...

- | | | |
|-----------------------|------------------------------|-----------------------------|
| headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| blurred vision? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| loss of focus? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| neck & shoulder pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| overall fatigue? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

All information found in this form will remain strictly confidential!

Please list any other visual or occupational problems that may appear from your computer use. _____

Do you wear Sunglasses? Yes No **If yes are they:** Prescription Non Prescription? (please circle one)

Please list any other glasses that you presently wear for recreation or work _____

Hobbies

(Did you know that specialty lenses, coatings and frames are available for many different tasks?)

- Basketball
- Road Cycling
- Mountain Biking
- Boating/Fishing
- Cards
- Computer
- Other (please list) _____
- Driving
- Gardening
- Golf
- Woodworking
- Gardening
- Painting
- Photography
- Racquet Ball
- Scuba Diving
- Skiing
- Swimming
- Stamp/Coin Collecting
- Football
- Flying
- Running

The following will give us an idea of how susceptible you are to many types of eyestrain. All questions are on a 0 to 5 scale. Zero being never 5 being often.

1. How often do you..

- focus on small objects? 0 1 2 3 4 5
- spend long periods of time reading or writing? 0 1 2 3 4 5
- go from indoor to outdoor light quickly? 0 1 2 3 4 5

2. How often are you exposed to...

- outdoor light? 0 1 2 3 4 5
- florescent light? 0 1 2 3 4 5
- bright indoor light? 0 1 2 3 4 5

3. How often do you experience...

- headaches on the job? 0 1 2 3 4 5
- blurred vision? 0 1 2 3 4 5
- tired eyes? 0 1 2 3 4 5
- glare from headlights? 0 1 2 3 4 5

Feel free to add any other pertinent information, you may think Dr. Teles needs to know regarding your visual needs.
