Barrett Vision Center

Please fill out the information below so we may update your records.

Today's Date: _____/_____/_____

Name: _____ Occupation: _____

Address: _____

City:_____ State: _____ Zip: _____

Daytime Phone # _____ Evening Phone # _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Email: _____

May we contact you by email and/or text messaging? Yes ___ No ___

FOR CHILDREN UNDER 18 YEARS OF AGE

Mothers Name: _____

Mothers Address: _____

Mothers Daytime Phone # _____ Mothers Evening Phone # _____

Mothers Date of Birth: _____/_____/_____ Mothers Social Security # _____-_____-_____

Fathers Name:_____

Fathers Address: _____

Fathers Daytime Phone # _____ Fathers Evening Phone # _____

Fathers Date of Birth: _____/_____/_____ Fathers Social Security # _____-_____-_____

PLEASE ANSWER THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

Do you wear glasses? Yes ___ No ___

Do you wear contact lenses? Yes ___ No ___

Going to purchase glasses? Yes ___ No ___

Interested in contact lenses? Yes___ No ___

Frequently get headaches? Yes ___ No ___

Do you ever see double? Yes ___ No ___

Have you ever had eye surgery? Yes___ No ___

Eye Injury Yes___ No ___

Are you Diabetic? Yes___ No ___

If female, are you pregnant? Yes___ No ___

HAVE YOU OR A BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING?

Glaucoma? Yes ___ No___

Turned/Crossed eye? Yes ___ No___

Macular Degeneration? Yes ___ No___

Colorblindness? Yes ___ No___

Lazy eye/Amblyopia? Yes ___ No___

Diabetes? Yes ___ No___

Do you use drops or medications for your eyes? Yes ___ No ___

If yes, please list:_____

Are you presently taking any medication (any medication at all)? Yes ____ No____

If yes, please list:_____

Are you allergic to any medication (any medication at all)? Yes ____ No____

If yes, please list:_____

Are you having any problems with your eyes at the current time? Yes ____ No____

If yes, please state: _____

_____

Questions or comments: _____

_____