Herman Advanced Family Eye Care

1402 Main Street
Bloomer, WI 54724

510 Second Street
Chetek, WI 54728

General Information

Date: _____/_____/_____

Last Name_____ First Name_____ MI_____ Birthday:____/____/____

M or F Parent / Legal Gaurdian / Spouse _____

Address:_____City:_____ State:_____ Zip:_____

Home Ph:( )_____ Work Ph:( )_____ Cell Ph:( )_____

Employer/School:_____ Occupation/School Grade:_____

Email Address:_____ Sports/Hobbies:_____

Emergency Contact:_____ Relation:_____ Phone: ( )_____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type:_____ How often do you replace them?:_____

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you taken eye medication? Yes No Why?_____

Are you currently Pregnant or Nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

Please circle and explain any of the following past or present conditions that apply:

Blurred Vision - Distance	Burning Eyes	Floaters or Spots	Headaches
Blurred Vision - Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive

Notes:

*** PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE***