CHRISTYN MAI, O.D. OPTOMETRIST

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PATIENT INFORMATION (PLEASE PRINT)

LAST NAME:	FIRST NAME:	M.I:	SEX: ☐ MALE ☐ FEMALE	D.O.B	AGE:

ADDRESS: ☐ NO CHANGE ☐ NEW	CITY:	STATE:	ZIP CODE:

CELL PHONE:	EMAIL:
OCCUPATION:	REFERRED BY:

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. I ALSO AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, AND I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

SIGNATURE:_____ DATE: _____

(If patient is under 18 years old, parent signature required)

SOCIAL SECURITY#: _____

INSURANCE ID#: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

☐ Routine Yearly Eye Health Exam
☐ Problem Related Exam for Eye Conditions / Diseases
☐ Eye Exam for Eye Glasses
☐ Eye Exam for Contact Lenses
☐ Laser Surgery Consultation
☐ Dry Eyes
☐ Others

DRY EYE QUESTIONNAIRES

- **Do your eyes ever feel dry, gritty, or sandy?**
  ☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly
- **Do you experience burning, stinging, or watering of the eyes?**
  ☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly
- **Do your eyes feel tired or heavy (especially later in the day)?**
  ☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly
- **Do you notice blurred or fluctuating vision that improves after blinking?** ☐ Yes ☐ No
- **Do your eyes feel worse in certain environments? Check all that apply.**
  ☐ Windy Conditions ☐ Air Conditioning/ Fans/ Heating ☐ Prolonged Screen Us

LIFESTYLE & HABITS

- **On average, how many hours per day do you spend using digital devices (computer, phone, tablet)?**
  [ ] <2 [ ] 2-4 [ ] 4-6 [ ] 6-8 [ ] >8
- **Do you use artificial tears, lubricating drops, or other eye drops?** ☐ No ☐ Yes - occasionally ☐ Yes - daily

TREATMENTS

- **Do you want to learn about treatment options for Dry Eyes?** ☐ Yes ☐ No