Diana Ciobanu, O.D.
& Associates

Welcome to Optometry at the Shops

Name: _____Cell Phone #: _____DOB_____

Home Address: _____

City: _____ Zip Code: _____

Email: _____ Occupation: _____

Vision Insurance and ID# _____

Primary's - Name/DOB/Last 4 of SS# _____

How were you referred to our office: _____

Preferred method for reminders? □ Email □ Text Message □ Postcard □ Other _____

Date of last Eye Exam: _____Do you wear glasses? _____When were they prescribed? _____

Do you wear or interested in contact lenses? _____ If so the type/brand: _____

Have you had LASIK? If so when?_____ Have you had any eye surgery?_____

Check any issues you may be having with your current glasses/contacts prescription:

□ Distance □ Reading □ Computer □ Distortion □ Night Driving □ Sun/Light Sensitivity □ Blur □ Discomfort

□ Dryness/Redness □ Other, explain: _____

What do you like or don't like about your current prescription? _____

Briefly explain any other vision problems you are currently experiencing:

_____

How many hours per day do you spend on a computer or electronic device? _____

Do you experience headaches or migraines, if so, when and how frequently?

_____

Please select any that apply: □ High Blood Pressure □ Diabetes □ Allergies □ Other _____

Family History of any health conditions? _____

What medications are you currently taking? _____

Please explain any allergies to medications you have: _____

Have you ever had an injury to your head or eyes, if so when did it occur?

_____

Hobbies/Recreation/Activities?_____

Any additional information that you feel would be helpful: _____

Patient/Guardian Signature:_____Date:_____