



**DR. STEPHEN R. BELANGER
DR. JOSEPH T. MARRA
OPTOMETRISTS**

Date _____

Last Name _____ First Name _____ MI _____

Social Security # _____ Spouse's Name _____

If a child, parent or guardian's name _____

Address _____

Date of birth _____ Referred by _____

The best telephone numbers to contact you during our normal business hours (9-5 M-F)?
 Home _____ Work _____
 Cell _____ Pager _____

Firm employed by _____ how many years? _____

Position and duties – i.e. job description, student, homemaker, etc _____

Describe your visual problems _____

Describe any pain or irritation to your eyes _____

Do you have headaches? _____ if so, how often? _____

List medical conditions _____ Medications _____

Name of family doctor _____

List allergies to medication _____

Have you ever had any disease or surgery of the eyes? _____

Do you family history of eye disease? _____

Do you have a family history of diabetes, high blood pressure, cancer, etc.? _____

Have you ever had an injury to your eyes or head? _____

Recreations and hobbies you engage in _____

Do you have unusual sensitivity to sunlight? _____ Do you smoke? _____

Please circle any problems you have recently experienced:

- | | | |
|-------------------------|-------------------------|------------------------|
| Loss of vision | Halos around lights | Mucous discharge |
| Blurred vision | Fluctuating vision | Redness |
| Loss of side vision | Dryness | Double vision |
| Excess tearing/watering | Distorted vision | Sandy gritty feeling |
| Floaters/floaters | Itching | Eye pain or soreness |
| Burning | Glare/light sensitivity | Foreign body sensation |

Do you wear contact lenses? _____ Type and brand _____

Remarks/Additional Information: