Return Visits

Gramercy Park Optical Services
344 Third Avenue
(Between 25-26 Streets)
New York, NY 10017
212.679.9690

Reason for visit: _____
Last eye exam: _____ By whom? _____
Who referred you to our office?_____
Do you wear glasses? …….. ☐ Yes ☐ No
Do you wear contact lenses ……..... ☐ Yes ☐ No
If yes, what type?_____

How much time do you spend on a computer? _____
Occupation: _____

Have you ever had an eye infection, injury or surgery?.. ☐ Yes ☐ No
If yes, please specify _____
Do you have a history of glaucoma, cataracts, lazy eye or any other eye problems? ……..…. ☐ Yes ☐ No
If so, please specify_____

Do any of your family members have glaucoma, cataracts, blindness or any other eye problems? ……..…… ☐ Yes ☐ No
If so, please specify _____

Do you have any medical problems, such as high blood pressure, diabetes, cardiovascular, thyroid, etc.? ……..…… ☐ Yes ☐ No
If so, please list_____
Do you take medications? ……..... ☐ Yes ☐ No
If so, please list_____
Are you allergic to any medications: ……..…… ☐ Yes ☐ No
If so, please list_____

Do you have frequent or severe headaches? …….. ☐ Yes ☐ No
Do you have pain in or around your eyes? ……..…… ☐ Yes ☐ No
Do you ever have double vision? ……..... ☐ Yes ☐ No
Do you ever see flashes of lights or lightning streaks?.... ☐ Yes ☐ No
Do you ever see floaters (black spots)? ……..... ☐ Yes ☐ No
Do you ever see halos or rings around lights? ……..... ☐ Yes ☐ No

Do you have eye care insurance? ……..….. ☐ Yes ☐ No
If yes, please name _____
Patient's date of birth _____
Patient SS# _____
Insured SS# _____

Thank you. We will be with you as soon as possible.