Name_____
Nickname_____
Street _____
City_____ State_____ Zip _____
Date of Birth_____ Age_____ Sex: M F
Home Phone _____
Cell Phone _____
E-mail Address_____
Employer/School _____
Occupation/Grade_____
Parent's/ Guardians Name _____
Emergency Contact Name_____
Emergency Contact Number _____

Today's Date_____

Last Eye Exam_____

Do You…

Currently wear glasses?	**Y**	**N**
If Yes, do you use them during sports?	**Y**	**N**
Currently wear contacts?	**Y**	**N**
If Yes, do you use them during sports?	**Y**	**N**
Do you currently experience any visual difficulties or have in the past?	**Y**	**N**

If yes, please explain_____
_____
_____

Athlete History: Please check all that apply.
Do you now or ever have had:

____Blurred Vision ____Double Vision

____Eye Strain ____ Color Deficiency

____Concussion: If Yes How many? _____

How long ago was you last concussion? _____

____ Sports Injuries: If Yes please List:

_____

_____

How did you hear about us?

___ Current Patient with Bellaire Family Eye Care
___ Professional Referral_____
___ Coach/Trainer _____
___ Other Athlete_____
___ Social Media _____
___Website/ Internet Search

Athlete Self-Assessment

Primary Sport _____

Level_____

Primary Position _____

Secondary Position_____

Do you ever feel you have difficulty "keeping your eye" on a moving object?	**Y**	**N**
Do you notice variations in your performance during a game or over a long period of time?	**Y**	**N**
Is your performance during a night competition the same as during the day?	**Y**	**N**
Do you experience loss of concentration during sports performance?	**Y**	**N**