

Name: _____ Age: _____ Today's Date: _____
 Birth Date: _____ SSN: _____ Last Eye Exam: _____
 Address: _____ Last Eye Doctor: _____
 City: _____ St: _____ Zip: _____ Last Medical Exam: _____
 Phone Number: (h) _____ (w) _____ Current Medical Dr.: _____
 E-mail: _____

Vision Insurance Plan: _____ Name of Insured: _____
 Member ID Number: _____ Employer: _____
 Spouse: _____ Referred by: _____

Reason for visit: _____

Medical History

Do you have any allergies to medications? Yes No If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? Yes No If yes, explain: _____
 Have you had any eye surgeries? Yes No If yes, explain: _____
 Have you ever had vision therapy? Yes No If yes, explain: _____
 Have you ever injured your eyes? Yes No If yes, explain: _____
 Do you wear glasses? Yes No If yes, how old is your present pair of lenses? _____
 Do you wear contact lenses? Yes No If yes, how old is your present pair or lenses? _____
 Type of contact lenses: Rigid Soft Extended Wear Other _____
 Name of lenses: _____ Are they comfortable? _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Visual System	current	past	never	Systemic System	current	past	never
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urogenital (kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood (Anemia, cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (thyroid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological (MS, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (acne, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (depression, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(asthma, bronchitis, emphysema)			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Please fill out the back side...

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

If yes, please describe: _____

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

What type of work do you do? _____

Do you go to school? Yes No If yes, where and grade level/field of study? _____

Do you play any sports? Yes No If yes, type and amount: _____

Other forms of exercise? _____

Do you have any hobbies? _____

How many hours per day do you:

Work on a computer? _____

Read? _____

Watch TV? _____

Play video games? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Systemic Disease/Condition	Yes	No	Not Sure	Relationship to you
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____				_____

Our goal is to provide the best, most complete, up-to-date care available. Our philosophy is preventive and developmental in approach. To provide this service in the most efficient manner, please be aware of the following office policies:

- Fees for services are due at the time those services are rendered.
- A deposit is required on all materials and balance due upon delivery.
- We reserve the right to charge for missed appointments not cancelled in advance.
- Visual training patients must notify us of absences in advance.
- There is a charge for written reports.
- Responsibility for payment is the patient's. Insurance agreements are between company and patient. We will assist with proper forms but require reimbursement from patients.

Signature: _____ Date: _____