

Name: _____ M/F Age: _____ Today's Date: ____ / ____ / ____
 Address: _____ Phone: _____
 City, State: _____ Zip: _____ Work/Cell: _____
 Birth Date: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____ Occupation: _____
 Email: _____ Employer: _____

Name of Vision Benefit Plan: _____ Name of Policy Holder: _____
 Name of Medical Insurance: _____ Name of Policy Holder: _____
 Employer of Policy Holder: _____ Birth Date of Policy Holder: ____ / ____ / ____

Do you have any allergies? no yes If yes, explain: _____

List any medications, prescribed or over the counter, that you take: (If you have a list of your medications, we can scan it into your chart)

LIST ANY OF THE FOLLOWING THAT YOU HAVE HAD: cataracts, glaucoma, eye surgery, retinal disease, eye injury:

Are you pregnant and/or nursing? no yes
 Do you wear glasses? no yes If yes, how old is your present pair of glasses? _____
 Do you wear contact lenses? no yes If yes, what brand do you wear? _____
 What power contacts do you wear? _____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	?	SELF OR 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"/>	_____
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 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

** Please turn this form over and complete side two **

Do you have visual difficulty when driving? no yes If yes, please describe:

How often do you experience headaches? Daily Weekly Intermittently Rarely Never

What do you feel is the cause(s) of these headaches? Sinus/Allergies Stress Diet/Caffeine Sleep Vision

Review of Systems

Do you have any PROBLEMS in the following areas:

	YES	NO	?		YES	NO	?
GENERAL HEALTH				EARS, NOSE, MOUTH, THROAT			
Acute Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES (if yes, answer the following)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When were you diagnosed? _____			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Most Recent HbA1c? _____			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Most Recent Blood Sugar? _____			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYMPHATIC / HEMATOLOGIC				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER NOT LISTED _____			

DO YOU USE TOBACCO PRODUCTS?

I certify that I have answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits for services rendered. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or those of my dependents. I understand that all fees are due at the time of service and are non-refundable. I have read and understand the HIPAA privacy policies for this office as posted.

X _____
SIGNATURE OF PATIENT (or parent if patient is a minor) DATE