VISION SOURCE™

DR. JOSEPH DIGIORGIO
DR. STEPHANIE DIGIORGIO

Orland Atrium Building
9031 W. 151St. Street
Orland Park
708 460-2010

Welcome to Our Office

(PLEASE PRINT)

Name _____ Today's Date _____Date of Last Exam _____

Address _____ Date of Birth _____Age _____

City _____ State _____ Zip _____ Sex: M____ F____ Social Security # _____

Home Phone (_____) _____ Spouse's (or Parent's) Name _____

Cell Phone (_____) _____ Medical Insurance _____

E-mail _____ VIsion Insurance _____

Occupation (or Grade) _____

Please Give Both Your Vision & Medical Insurance Cards to the Receptionist

How did you first hear about **VISION***Source* ?

- ❒ Referred by a **friend or a relative**

  If so, **who may we thank**? _____
- ❒ Referred by another **doctor or teacher**

  If so, who? _____
- ❒ **Website,** ❒ **Google,** ❒ **Yelp,** ❒ **Facebook,** _____
- ❒ **Office Sign**

What is the **Main Purpose** of this visit?

What do you like about your present **Contact Lenses** or **Eyeglasses**?

_____

Any problems with your present **Contact Lenses** or **Eyeglasses**?

_____

Are you planning to **Update your Eyeglasses today?**

_____

DO YOU HAVE ANY OF THE FOLLOWING WITH YOUR EYES?

- Blurry distance vision .....Yes / No
- Blurry near vision .....Yes / No
- Difficulty Working up close .....Yes / No
- Eye strain / tired eyes.....Yes / No
- Sensitivity to light .....Yes / No
- Glare or reflections.....Yes / No
- Difficulty Seeing at night.....Yes / No
- Double vision .....Yes / No
- Loss of side vision.....Yes / No
- Flashes / Floaters in vision.....Yes / No
- Sudden loss of vision .....Yes / No
- Redness.....Yes / No
- Gritty or sandy feeling .....Yes / No
- Dryness, Burning or Itching .....Yes / No
- Watery or Tearing eyes.....Yes / No
- Mucous discharge.....Yes / No
- Uncomfortable contacts.....Yes / No

Other_____

LIST ALL CURRENT MEDICATIONS (Rx or Over the Counter)

		Name of Medication
High Blood Pressure Meds.....	Yes / No	_____
Diabetes Meds or injections ...	Yes / No	_____
Oral Contraceptives	Yes / No	_____
Eye Drops	Yes / No	_____
Other Medicines.....	Yes / No	_____
Under a physicians care?.....	Yes / No	Name: _____

Please circle any family history for the following eye conditions

		Relationship to patient
Blindness	Yes / No	_____
Cataracts.....	Yes / No	_____
Glaucoma.....	Yes / No	_____
Macular Degen.....	Yes / No	_____
Retinal Detach.....	Yes / No	_____
Lazy Eye.	Yes / No	_____
Other.....	Yes / No	_____

Have you ever worn or are you currently wearing contact lenses?.....Yes / No

What kind?_____ Solutions used_____

Are you interested in contact lenses? .....Yes / No

(OVER PLEASE)

❋ *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.* ❋

- 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: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea, ❒ Hepatitis, ❒ HIV, ❒ Syphilis

REVIEW OF MEDICAL SYSTEMS:

- Do you have any allergies to medications?.....Yes / No If yes, please explain_____
- Are you pregnant and /or nursing?.....Yes / No

Vascular / Cardiovascular

- Diabetes .....Yes / No
- Heart Disease.....Yes / No
- High Blood Pressure .....Yes / No
- Vascular Disease.....Yes / No

Allergic/Immunologic.....Yes / No

Skin Conditions.....Yes / No

Endocrine

- Thyroid / other glands .....Yes / No

Psychiatric Condition .....Yes / No

Ears, Nose, Mouth, Throat

- Allergies / Hay fever.....Yes / No
- Sinus congestion .....Yes / No
- Runny Nose.....Yes / No
- Post-nasal drip.....Yes / No
- Chronic cough.....Yes / No
- Dry throat/mouth .....Yes / No

Respiratory

- Asthma ..... Yes / No
- Chronic Bronchitis..... Yes / No
- Emphysema..... Yes / No

Neurological

- Headaches..... Yes / No
- Migraine History ..... Yes / No
- Seizures..... Yes / No

Gastrointestinal

- Diarrhea..... Yes / No
- Constipation..... Yes / No

Genitourinary

- Genitals/kidneys / bladder..... Yes / No

Bones / Joints / Muscles

- Rheumatoid Arthritis..... Yes / No
- Muscle pain..... Yes / No

Lymphatic / Hematological

- Anemia ..... Yes / No
- Bleeding problems ..... Yes / No

Constitutional

- Fever, Weight loss/gain..... Yes / No

Circle any hobbies, Sports or special interests you engage in:

- Baseball
- Basketball
- Football
- Hockey
- Boating
- Fishing
- Skiing
- Soccer
- Golf
- Tennis
- Musical instruments
- Sewing or needlework
- Home workshop
- Card playing
- Biking
- Scrap Booking

Other:_____

Do You . . .

- spend more than **30 minutes per day on computer**? .....Yes / No
- **wear bifocals?** If so, are you bothered by head tilting, or restricted areas of vision correction?.....Yes / No
- have **more than one pair** of current prescription glasses?.....Yes / No
- have interest in **thinner, lighter lenses**? .....Yes / No
- have times you would rather **not wear glasses**? .....Yes / No
- have interest in **newer contact lens technology**? .....Yes / No
- want a **non-surgical option** to LASIK eye surgery? .....Yes / No
- spend more than an hour per day **outdoors or driving**? .....Yes / No
- have **U.V. protecting** prescription sunglasses? .....Yes / No
- have problems with **glare or night driving**? .....Yes / No

Payment Policy & Receipt of "Notice of Privacy Practices":

Please note that Well Vision exams are billable to Vision Plans. Patients requiring a Physician Eye Report or for those with medical history, diagnosis or medical conditions, such as Diabetes, Cataracts, History of Cataract surgery, eye infections, etc., that can affect the eyes will be billed to Medical Insurance Plans.

Payment is required at the time of service. Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, ***please contact your representative***. All insurance referrals need to be given to us ***before*** services. We ***do not*** guarantee the accuracy of benefit information given to us by insurance companies**!**

Please understand that financial responsibility is yours, not your insurance company's.

How will you settle your account today? ❒ Check ❒ Cash ❒ Credit

I personally guarantee payment and any necessary collection fees to collect payment of materials and/or services rendered. I authorize the release of any medical or other information necessary to process my care and acknowledge that I have reviewed this offices ***"Notice of Privacy Practices".***

Patient / Guardian Signature _____ *Thank You*