

Welcome to Our Office

(PLEASE PRINT)

Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone (_____) _____
 Work Phone (_____) _____
 Employer (or School) _____
 Occupation (or Grade) _____

Today's Date _____ Date of Last Exam _____
 Date of Birth _____ Age _____
 Previous Doctor _____ City _____
 Sex: M ___ F ___ Social Security # _____
 Spouse's (or Parent's) Name _____
 Medical Insurance _____
 Vision Insurance _____

How did you first hear about **VISIONSource** ?

- Referred by a friend or a relative
 If so, who may we thank? _____
- Referred by another health care practitioner or teacher
 If so, who? _____
- Yellow Pages
- Cable T.V.
- Office sign
- Other _____

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?

Do you wish to replace your eyeglasses today?

What other family members are **VISIONSource** patients?

DO YOU HAVE ANY OF THE FOLLOWING WITH YOUR EYES?

- Blurry distance vision.....Yes / No
 - Blurry near vision.....Yes / No
 - Difficulty Reading.....Yes / No
 - Difficulty Working up close.....Yes / No
 - Eye strain / tired eyes.....Yes / No
 - Trouble reading or learning at work, school, or other activity ..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	_____
Are you currently 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

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

- Do you use Tobacco productsYes / No If yes, type / amount / how long: _____
- Do you drink alcoholYes / 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:

- | | |
|---------------------|------------------------|
| • Computer terminal | • Skiing |
| • Baseball | • Golf |
| • Basketball | • Tennis |
| • Football | • Musical instruments |
| • Hockey | • Sewing or needlework |
| • Flying | • Home workshop |
| • Boating | • Card playing |
| • Fishing | • Other: |

Additional comments:


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
- 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” Form:

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  

I personally guarantee payment for all services rendered. I authorize the release of any medical or other information necessary to process my care. I acknowledge that I have reviewed this offices “**Notice of Privacy Practices**”, and additional copies are available to me upon my request.

Patient / Guardian Signature _____

Thank You