eyeneye VISION CENTER
MEMBER VISION SOURCE NETWORK

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Welcome to Our Office

Today's Date: _____

Last _____

First _____ MI _____

Address_____

City _____ State _____ Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Employer (or School) _____

Occupation (or Grade) _____

Date of Birth _____ Age _____ Gender M F

Marital Status (circle one): Single Married Separated

Divorced Other_____

Race (circle one): Black or African Amcan White Asian

Native Amcan Indian Pacific Islander

Ethnicity: Hispanic Non-Hispanic Other_____

Preferred Language: _____

Email Address _____

Spouse (or Parent) Name _____

Spouse (or Parent's) Work _____

What is the major purpose of this visit?

_____

_____

Are you having any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office for your needs?

- ❑ Another Doctor
- ❑ Insurance List
- ❑ Radio
- ❑ Other _____
- ❑ Signage/Location
- ❑ Newspaper
- ❑ Flyer

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN/ID#_____
Subscriber DOB _____
Relationship to Subscriber _____
Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN/ID# _____
Subscriber DOB _____
Relationship to Subscriber _____
Secondary Medical Insurance _____
Subscriber Name _____
Subscriber SSN/ID#_____
Subscriber DOB _____

Family History

Check all that apply:

Disease/Condition		**Relationship**
Blindness	❑	_____
Cataract	❑	_____
Corneal Problems	❑	_____
Crossed Eyes/Lazy Eyes	❑	_____
Glaucoma	❑	_____
Macular Degeneration	❑	_____
Retinal Detachment/Disease	❑	_____
Arthritis	❑	_____
Cancer	❑	_____
Diabetes	❑	_____
Heart Disease	❑	_____
High Blood Pressure	❑	_____
Kidney Disease	❑	_____
Lupus	❑	_____
Thyroid Disease	❑	_____
Other _____	❑	_____
None of the Above	❑	_____

Do you … *(check all that apply)*

- ❑ Work at a computer? _____ hours per week.
- ❑ Drive at night?
- ❑ Think you might benefit from thinner, lighter lenses?
- ❑ Have interest in updating your eyeglasses frames?
- ❑ Like to change the look of your eyeglasses often?
- ❑ Spend time outdoors? _____ hours per week? ____
- ❑ Have prescription sunglasses?
- ❑ Prefer not to wear glasses at times?
- ❑ Want information on Vision Correction surgery?
- ❑ Have more than 1 pair of current Rx glasses?
- ❑ Have children?
- ❑ Have family members in need of eye care?

If you wear bifocals, do the lines or head tilting bother you?

Yes No

Eye Health History

The information in this confidential case history form is critical to the evaluation of your vision and health.

Date of Last Eye Exam _____

By Whom? _____

Do you wear eyeglasses? **Y N**

Have you ever tried contact lenses? **Y N**

Do you currently wear contact lenses? **Y N**

What kind? _____

Solutions Used _____

Would you prefer clear lenses or colored lenses to change the color of your eyes? _____

If you wear contact lenses, are you satisfied with the vision and comfort? **Y N**

Do you have a backup pair of eyeglasses? **Y N**

Have you ever been diagnosed or treated for the following:

- ❑ **Cataracts**
- ❑ Corneal Abrasion
- ❑ Eye Infection
- ❑ Eye Injury
- ❑ **Glaucoma**
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ **Macular Degeneration**
- ❑ Retinal Detachment
- ❑ Other eye disorders

Do you experience or have you ever experienced:

- ❑ Blurry vision
- ❑ Burning
- ❑ Tearing/watering
- ❑ Headaches
- ❑ Double vision
- ❑ Occasional dryness
- ❑ Redness
- ❑ Loss of vision
- ❑ Loss of side vision
- ❑ Tired eyes
- ❑ Eye pain/soreness
- ❑ Flash of light
- ❑ Floaters/spots
- ❑ Grittiness
- ❑ Itchiness
- ❑ Glare/light sensitivity
- ❑ Crossed eyes/eye turn
- ❑ Trouble seeing at night
- ❑ Distorted vision/halos
- ❑ Mucous discharge
- ❑ Foreign body sensation
- ❑ Sties or Chalazion
- ❑ Chronic infection of eye or lid
- ❑ NONE OF THE ABOVE

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. (Check box)

Do you use tobacco products? **Y N**
If yes, type/amount/how long? _____

Do you drink alcohol? **Y N**
If yes, type/amount/how long? _____

Do you use illegal drugs? **Y N**
If yes, type/amount/how long? _____

Have you ever been exposed to or infected with:

- ❑ Gonorrhea
- ❑ Hepatitis
- ❑ HIV
- ❑ Syphilis

Medical History

Name of Family Physician: _____

Phone/Fax: _____

Date of Last Physical Exam: _____

Do you have any allergies to medications? Y N

If yes, please explain _____

_____

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

_____

_____

_____

Are you currently pregnant or nursing? **Y N**

Weight: _____ Height: _____

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

_____

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

Constitutional
- Fever, Weight Loss/Gain ❑

Integumentary (Skin) ❑

Neurological
- Headaches/Migraines ❑
- Stroke ❑
- Seizures ❑

Endocrine
- Thyroid/Other Glands ❑

Ears, Nose, Mouth, Throat
- Allergies/Sinus ❑
- Chronic Cough ❑
- Dry Throat/Mouth ❑

Respiratory
- Asthma ❑
- Chronic Bronchitis ❑
- Emphysema ❑

Vascular/Cardiovascular
- **Diabetes** ❑
- Heart Pain ❑
- **High Blood Pressure** ❑
- Vascular Disease ❑

Gastrointestinal
- Crohn's Disease ❑
- Acid Reflux/IBS ❑

Genitourinary
- Genitals/Kidney/Bladder ❑

Bones/Joints/Muscles
- Rheumatoid Arthritis ❑
- Muscle Pain ❑
- Joint Pain ❑

Lymphatic/Hematologic
- Anemia ❑
- Bleeding Problems ❑

Allergic/Immunologic ❑

Psychiatric ❑

NONE OF THE ABOVE ❑

If you checked any of the above or have a condition not listed, please explain & list medications:

_____

_____

Reviewd by: _____