i Vision Optometry

WELCOME TO OUR OFFICE

Patient Information

Name: ______________________ Today's Date: ____/____/____

Address: ______________________ Age: ______ ☐Male ☐Female

City: ____________ State: ______ Zip: ________ Date of Birth: ____/____/____

Email: ______________________ Employer/School: ____________

Spouse or Guardian's Name: ______________________ Occupation/Grade: ____________

☐Home Phone ____________

☐Work Phone ____________

☐Cell Phone ____________

Emergency Contact Name: ______________________

Home Phone ____________ Relationship: ____________

Work Phone ____________ Cell Phone ____________

How were you referred to our office?

☐Friend or Relative: ____________ ☐Doctor: ____________

☐VSP ☐Bridge USA ☐Lighthouse Magazine ☐Yellow Pages ☐Internet ☐other ____________

Lifestyle Questions

☐Do you think you might benefit from thinner/lighter lenses?

☐Do you have interest in Laser vision correction surgery?

☐ Are you bothered by glare or reflection, particularly at night?

☐Do you use computer? ________ hours

☐Do you have prescription sunglasses?

☐Do you participate in any sports? ____________

Insurance Information

VISION Insurance Name ____________ Subscriber I.D.# ____________

Subscriber's Name ____________ Date of Birth ________ Relationship ________

MEDICAL Insurance Name ____________ Subscriber I.D.# ____________

Subscriber's Name ____________ Date of Birth ________ Relationship ________

Eye Health History

What is the main reason for your visit today? ______________________

Date of last eye exam: ____________ Doctor's Name: ______________________

Do you wear eyeglasses? ☐Yes ☐No If yes, please check: ☐All the time ☐Occasionally ☐Computer ☐Reading

☐TV ☐Other: ____________ How old is your current pair of glasses? ____________

Please describe any concerns you may have with your glasses: ______________________

____

Have you ever tried contact lenses? ☐Yes ☐No If no, are you interested in trying contact lenses? ☐Yes ☐No

Do you currently wear contact lenses? ☐Yes ☐No

If yes, are you interested in updating your contact lens prescription today? ☐Yes ☐No

Please turn this form over and continue on Page 2

Eye Health History - continued

Have you or a blood relative ever experienced, been diagnosed or treated for any of the following?

	Yourself
Blurred Vision - Distance	☐Yes ☐No
Blurred Vision - Near	☐Yes ☐No
Eye Injury	☐Yes ☐No
Itching Eyes	☐Yes ☐No
Watering Eyes	☐Yes ☐No
Eye Pain or Soreness	☐Yes ☐No
Foreign Body Sensation	☐Yes ☐No
Seeing Flashes/Floaters	☐Yes ☐No
Eye Strain	☐Yes ☐No
Discharge from Eyes	☐Yes ☐No
Distorted Vision/Halos	☐Yes ☐No
Light Sensitivity	☐Yes ☐No
Double Vision	☐Yes ☐No
Dry Eyes	☐Yes ☐No
Red Eyes	☐Yes ☐No
Sties of Chalazion	☐Yes ☐No
Dizzy Spells	☐Yes ☐No
Twitching Eyelid	☐Yes ☐No

	Yourself	Family
Glaucoma	☐Yes ☐No	☐Yes ☐No
Cataract	☐Yes ☐No	☐Yes ☐No
Lazy Eyes	☐Yes ☐No	☐Yes ☐No
Crossed/Turned Eyes	☐Yes ☐No	☐Yes ☐No
Vision Poor	☐Yes ☐No	☐Yes ☐No
Iritis/Uveitis	☐Yes ☐No	☐Yes ☐No
Ptosis	☐Yes ☐No	☐Yes ☐No
Night Vision Poor	☐Yes ☐No	☐Yes ☐No
Loss of Side Vision	☐Yes ☐No	☐Yes ☐No
Temporary Loss of Vision	☐Yes ☐No	☐Yes ☐No
Color Vision Poor	☐Yes ☐No	☐Yes ☐No
Loss of Vision	☐Yes ☐No	☐Yes ☐No
Nystagmus	☐Yes ☐No	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	☐Yes ☐No
Corneal Abrasions	☐Yes ☐No	☐Yes ☐No
Retinal Detachment	☐Yes ☐No	☐Yes ☐No
Retinal Disease	☐Yes ☐No	☐Yes ☐No
Keratoconus	☐Yes ☐No	☐Yes ☐No

Medical History

Date of last physical exam: ____________ Dr's Name: ______________________________ Phone#: ______________________

1. Do you have any allergies to medications or any other substances? ☐Yes ☐No

   If Yes, please list: ____

2. List any medications you are currently taking including oral contraceptives, aspirin, over the counter meds, eye drops.

   ____

   Pharmacy Name: ______________________________ Phone#: ______________________

3. List all major injuries, surgeries and/or hospitalizations you have had: ______________________

   ____

4. Are you pregnant or nursing? ☐Yes ☐No

5. Use of tobacco products? ☐Yes ☐No Do you drink alcohol ? ☐Yes ☐No Use other substances? ☐Yes ☐No

Have you or a blood relative ever experienced, been diagnosed or treated for any of the following?

	Yourself	Family
Migraine Headache	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No	☐Yes ☐No
Hay Fever	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No
Cholesterol	☐Yes ☐No	☐Yes ☐No
Hemic Lymphatic Disease	☐Yes ☐No	☐Yes ☐No
Heart Condition	☐Yes ☐No	☐Yes ☐No
Kidney Disease	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No
Respiratory System	☐Yes ☐No	☐Yes ☐No
Gastrointestinal Disorders	☐Yes ☐No	☐Yes ☐No

	Yourself	Family
Cancer	☐Yes ☐No	☐Yes ☐No
Hepatitis (type ______)	☐Yes ☐No	☐Yes ☐No
Skin Condition	☐Yes ☐No	☐Yes ☐No
Muscular, Skeletal Systems	☐Yes ☐No	☐Yes ☐No
Stroke	☐Yes ☐No	☐Yes ☐No
Thyroid Conditions	☐Yes ☐No	☐Yes ☐No
Pacemaker	☐Yes ☐No	☐Yes ☐No
Psychiatric	☐Yes ☐No	☐Yes ☐No
Shingles	☐Yes ☐No	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	☐Yes ☐No
Drug Sensitivity	☐Yes ☐No	☐Yes ☐No