Name:
Account#:

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

Preferred Contact#: ❒ Home ❒ Work ❒ Cell Marital Status: ❒Sing ❒Mar ❒Div ❒Wid ❒Sep

SSN:_____ DOB:_____ Sex: ❒ M ❒ F

Preferred Language: ❒ English ❒ Spanish ❒ Other_____

Street Address/City/State/Zip:_____

Billing Address:_____

Email Address:_____Employer/Occupation:_____

Full Time Resident? ❒ Y ❒ N If No, Other Address:_____

Primary Care Physician:_____ Address:_____

Who Can We Thank For Referring You To Our Practice:

❑ Family/Friend
❑ Social Media
❑ Website
❑ Employer
❑ Insurance
❑ Doctor: _____
❑ Other: _____

GUARANTOR OR RESPONSIBLE PARTY: ❒ Self (Patient) ❒ Other (If Patient Is Minor)

If Other, Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

DOB:_____Relationship To Patient:_____

EMERGENCY CONTACT (Other than telephone number listed above)

Name:_____Relationship To Patient:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

PRIMARY MEDICAL INSURANCE

Company:_____ID#:_____Group#:_____

Policyholder Name:_____DOB:_____Relationship To Patient:_____

SECONDARY MEDICAL INSURANCE

Company:_____ID#:_____Group#:_____

Policyholder Name:_____DOB:_____Relationship To Patient:_____

VISION INSURANCE

ID#:_____Group#:_____Policyholder Name:_____

DOB:_____Relationship To Patient:_____

PATIENT MEDICAL HISTORY **NAME:**_____ **DATE:**_____

Please check YES or NO if you have or ever had any of the following:

❒ Y ❒ N Cancer - Type_____
❒ Y ❒ N Taken Flomax / Hytrin / Cardura
❒ Y ❒ N High Blood Pressure
❒ Y ❒ N Stroke / CVA
❒ Y ❒ N Heart Disease / Murmur
❒ Y ❒ N Heart Attack
❒ Y ❒ N Congestive Heart Failure
❒ Y ❒ N Irregular Heartbeat / Palpitations
❒ Y ❒ N Asthma
❒ Y ❒ N COPD
❒ Y ❒ N Migraines
❒ Y ❒ N Arthritis
❒ Y ❒ N Sleep Apnea - Use a CPAP? ❒Y ❒N

❒ Y ❒ N High Cholesterol
❒ Y ❒ N Thyroid Disease
❒ Y ❒ N Diabetes – ❒Oral ❒Diet ❒Insulin
❒ Y ❒ N GERD
❒ Y ❒ N Kidney Disease
❒ Y ❒ N Kidney Stones
❒ Y ❒ N Liver Disease
❒ Y ❒ N Hepatitis – ❒A ❒B ❒C
❒ Y ❒ N Auto-Immune Disease – Type_____
❒ Y ❒ N Infectious Diseases_____
❒ Y ❒ N Dementia / Memory Loss
❒ Y ❒ N MRSA

Have you received a pneumonia vaccine? ❒ Y ❒ N

Have you ever smoked? ❒ Y ❒ N - Do you still smoke? ❒ Y ❒ N

Do you drink alcohol? ❒ Y ❒ N - ❒Daily ❒Occasionally ❒Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

❒ Bypass
❒ Pacemaker
❒ Heart Stints
❒ Knee Replacement
❒ Other: _____

❒ Hip Replacement
❒ Prostate
❒ Colostomy
❒ Mastectomy

❒ No Surgical Procedures
❒ Thyroidectomy
❒ Appendectomy
❒ Gallbladder
❒ Back Surgery

❒ Cataract Surgery
❒ LASIK / RK
❒ Retinal Detachment
❒ Cornea Transplant
❒ Glaucoma Procedure
❒ Eyelid Procedure

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

❒ Cataracts
❒ Glaucoma
❒ Macular Degeneration

❒ Diabetic Retinopathy
❒ Corneal Disease
❒ Amblyopia / Lazy Eye

❒ Other_____
❒ Other_____
❒ Other_____

ALLERGIES

❒ Yes – Please list below ❒ No Known Allergies Latex Allergy? ❒ Yes ❒ No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of: (Mother, Father, Siblings, Grandparents)

Diabetes ❒ Y ❒ N Who:_____
Glaucoma ❒ Y ❒ N Who:_____
Macular Degeneration ❒ Y ❒ N Who: _____
Blindness ❒ Y ❒ N Who: _____
Adopted/Unknown ❒ Y ❒N

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.

REVIEW OF SYSTEMS

NAME:_____ DATE:_____

Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- ☐ Overall Healthy
- ☐ Weight Loss / Gain
- ☐ Fatigue
- ☐ Fever and Chills
- ☐ Weakness

Integumentary (Skin)

- ☐ Skin Cancer
- ☐ Rash
- ☐ Bruising
- ☐ Suspicious growths
- ☐ Itching

Ears/Nose/Mouth/Throat

- ☐ Dry Mouth
- ☐ Sinus Pain / Infections
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Wears hearing aids

Respiratory

- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Oxygen use
- ☐ Shortness of Breath

Cardiovascular

- ☐ Chest Pain
- ☐ Hypertension
- ☐ Heart attack
- ☐ Heart Surgery
- ☐ Palpitations

Gastrointestinal

- ☐ Heartburn / Acid reflux
- ☐ Diverticulitis
- ☐ Nausea
- ☐ Hernia
- ☐ Ulcers

Musculoskeletal

- ☐ Arthritis
- ☐ Back pain
- ☐ Swelling of joints
- ☐ Stiffness
- ☐ Muscle pain / joint pain

Neurological

- ☐ Memory Loss
- ☐ Headaches
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Tremors

Endocrine

- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Frequent Urination
- ☐ Excessive thirst

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Allergies / Immunological

- ☐ Allergic reaction to medications
- ☐ Allergic reaction to foods
- ☐ Seasonal / Environmental allergies
- ☐ Autoimmune disease

Other conditions or medical problems not listed?:

_____

_____

_____

X_____ _____ X_____ _____

Patient Signature Date Parent or Guardian Signature Date

Name:_____ Date:_____ Acct#:_____

VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation:_____

Hobbies:_____

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment	**Circle One**			
Would you like to be less dependent on glasses??	Distance		Near	Both
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty performing detailed work (sewing, threading a needle, baiting a hook)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

Please circle the activities you would prefer to do with less dependence on glasses:

Reading Seeing pill bottles Looking at a menu Looking at your watch Using a cell phone

Card or table games Sewing Applying makeup Using a computer

View dashboard of car Seeing price tags/shelves Shopping Bingo Driving

Playing sports, like golf Watching TV Watching live sports Going to movies Swimming

X_____ _____ X_____ _____

Patient Signature Date Parent or Guardian Signature Date