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Vision Source

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PATIENT INFORMATION

Welcome to our office. To better serve your vision and health care needs we need you to please complete this questionnaire and return it to the receptionist when finished. If you have any questions please ask and we will be happy to assist.

Today's Date: _____

Patient Name: _____ **Home phone #**: _____

First **MI** **Last** **Cell phone #**: _____

Date of Birth: _____ **Age:** _____ **Social Security No**._____

Home Address: _____

Street/PO Box **City** **State** **Zip Code**

Mailing Address: _____

Street/PO Box **City** **State** **Zip Code**

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married **Gender:** ☐ Male ☐ Female

Email Address: _____ Do we have your permission to email you information regarding confirmations, glasses and/ or contact lens orders, and recalls? **Y/N**

Patient's or parent's employer: _____

Check Appropriate Box: ☐ Employed Full-Time ☐ Employed Part-time ☐ Unemployed ☐ Retired

Parent's Social Security No. (If patient is a minor): _____

Parent's Date of Birth (If patient is a minor): _____

Work Phone No.: _____ **Spouse or Parent's name:** _____

Spouse's employer: _____ **Work Phone No.:** _____

Medical insurance company: _____

Policy holder: _____ **Policy Holder Social Security No.:** _____

ID #: _____ **Group #:** _____

Vision insurance company: _____

Policy holder: _____ **Policy Holder Social Security No.:** _____

Referred by: _____

MEDICAL HISTORY QUESTIONNAIRE

Please Print

Name: _____ **Date:** _____

Medical Doctor: _____ **Last medical exam**: _____

Last Eye Exam: _____

List ALL ALLERGIES to medication and foods: _____

List ALL current medications (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

_____

P**harmacy:** _____ List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

FAMILY HISTORY

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO PATIENT
Glaucoma			
Cataract			
Crossed Eyes			
Macular Degeneration			
Retinal detachment/Disease			
Blindness			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other			

SOCIAL HISTORY

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

New US Healthcare law requires us to ask the following:

Do you drink alcohol? If yes, how often?	YES	NO
Do you smoke? If yes, how long?	YES	NO
Height:	Weight:	
Hobbies or special eyewear needs:		

REVIEW OF SYSTEMS

Are you currently having or have a history of the following conditions?

If **YES**, please circle symptoms that apply and provide information below**.**

Patient's current or past eye history:

Redness, gritty feeling, itching, dryness, burning, tired eyes	YES	NO
Loss of vision	YES	NO
Blurry vision	YES	NO
Distorted vision and or halos	YES	NO
Loss of side vision	YES	NO
Double vision If yes, how long and which eye affected?	YES	NO
Glare/light sensitivity	YES	NO
Eye pain and or soreness	YES	NO
Foreign body sensation	YES	NO
Flashes, floaters, tearing or discharge	YES	NO
Chronic infections of the eye or lids	YES	NO
Styes or Chalazion	YES	NO
Glaucoma	YES	NO
Cataracts Cataract Surgery: **Y / N** Location: Surgeon: Left / Right / Both Date(s) of Surgery:	YES	NO
Macular Degeneration or retinal disease	YES	NO
Have you ever had eye surgery?	YES	NO
Have you ever had an eye injury?	YES	NO
Do you wear glasses or contact lenses? If yes, for how long?	YES	NO
Have you ever had crossed eyes, lazy eye, drooping eyelid or prominent eyes?	YES	NO
Do you plan on changing your eye wear today?	YES	NO

Are you currently having or have had a history of the following medical conditions?

Patient's current or past medical history **(Please circle those that apply):**

CONSTITUTIONAL SYSTEM: cancer, developmental disabilities, fever, weight loss or other	YES	NO
EARS, NOSE, THROAT: hearing loss, sinus congestion or chronic sinus infections, runny nose, dry mouth/throat or chronic cough	YES	NO
VASCULAR/CARDIOVASCULAR-irregular heartbeat, chest pain, high blood pressure, vascular disease, congestive heart failure, stroke/CVA	YES	NO
RESPIRTORY: cigarette smoke, asthma, chronic bronchitis, wheezing, emphysema, COPD, sleep apnea	YES	NO
GASTROINTESTINAL: Crohn's, colitis, acid reflux, celiac disease, genitals, kidney or bladder infections or disease	YES	NO
GENITOURINARY: kidney disease, prostate disease/cancer, STD – herpetic/chlamydia	YES	NO
MUSCULOSKELETAL: arthritis, fibromyalgia, muscular dystrophy, osteoporosis	YES	NO
INTEGUMENTARY: eczema, rosacea, psoriasis, herpes zoster/shingles, skin rash, scaling, acne	YES	NO
NEUROLOGICAL: Multiple Sclerosis, Epilepsy, Cerebral Palsy, tumor, stroke/CVA, weakness, numbness, tingling, headaches, migraines or seizures	YES	NO
PSYCHIATRIC: depression, attention deficit, anxiety disorder, bipolar disorder, other	YES	NO
ENDOCRINE- diabetes, Thyroid disease, Hormonal dysfunction, heat or cold intolerance, hair loss or growth, changes in menstrual cycle	YES	NO
HEMOTOLOGIC/LYMPHATIC- anemia, bleeding problems, hepatitis, high cholesterol, ulcer	YES	NO
ALLERGIC/IMMUNOLOGIC: Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, seasonal allergies, drug allergies, hay fever symptoms	YES	NO
ARE YOU PREGNANT? If Yes, how many weeks?	YES	NO