

# Welcome To Vision Specialties

Advanced Eye Care For Your Family

Please help us meet your vision and eye health needs by providing the following information

Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
First Middle Initial Last Preferred Name

Address \_\_\_\_\_ SS# \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Email address \_\_\_\_\_

Spouse's name, if married \_\_\_\_\_ Parent's name, if patient is a minor \_\_\_\_\_

Name of Medical Doctor \_\_\_\_\_ Last Medical Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Eye Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Vision insurance co. \_\_\_\_\_ Medical insurance co. \_\_\_\_\_

How will you settle your account today? Check Cash Credit Card Payment Program

If you were referred, whom may we thank for referring you to our office? \_\_\_\_\_

If you were not referred, how did you learn about our office?

Location Qwest Yellow Pages Regional Directory Yellow Pages Other \_\_\_\_\_

I understand that I am ultimately responsible for all fees and agree to pay for all services rendered. Although I may have insurance coverage, I understand and agree to be responsible for all fees billed to my insurance company should payment be declined. (Please Sign Here) \_\_\_\_\_

## VISION AND EYEWEAR INFORMATION

Please list any complaints about your current glasses or contacts. \_\_\_\_\_

Do you wear contact lenses? Yes No

Do you spend significant time working on a computer? Yes No

If so, are you satisfied with your vision and comfort? Yes No

Hobbies \_\_\_\_\_

What type do you wear?  
Gas Permeable Disposable Soft Soft (yearly)

If you wear glasses, would you benefit from thinner, lighter lenses? Yes No

Do you have more than one pair of glasses? Yes No

How old are your current lenses? \_\_\_\_\_

Do you spend a lot of time outdoors? Yes No

Which solutions do you use? \_\_\_\_\_

Laser vision correction is an option for many people. Do you desire information or a free consultation? Yes No

Are you interested in a "test drive" of the latest in contact lens design? Yes No

## FAMILY HISTORY

Do your parents, grandparents, siblings, or children have any of the following conditions?

<u>CONDITION</u>	<u>RELATIONSHIP</u>	<u>CONDITION</u>	<u>RELATIONSHIP</u>
Blindness	Yes No _____	Cancer	Yes No _____
Cataract	Yes No _____	Diabetes	Yes No _____
Glaucoma	Yes No _____	Heart Disease	Yes No _____
Macular Degeneration	Yes No _____	Thyroid Disease	Yes No _____
Retinal Disease	Yes No _____	Other	_____

Please turn form over and complete back side

**SOCIAL HISTORY**

All information about our patients is kept strictly confidential.

Do you use tobacco products? Yes No If yes, type / amount / how long? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, type / amount / how long? \_\_\_\_\_

Do you use illegal drugs? Yes No If yes, type / amount / how long? \_\_\_\_\_

Do you drive? Yes No If yes, do you have difficulty with your vision when driving? Yes No If yes, please explain or describe. \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**MEDICAL HISTORY and REVIEW OF SYSTEMS**

Please list all medications taken, including homeopathic remedies, birth control pills, and over the counter medications.

Are you allergic to any medications? Yes No If so, please list or explain: \_\_\_\_\_

Please list all major injuries and surgeries you have undergone: \_\_\_\_\_

Please circle any of the following that you have had: lazy eye, crossed eyes, drooping eyelid, glaucoma, retinal disease, cataracts, chronic eye infections, eye injury

Are you pregnant or nursing? Yes No

Please check any of the following that have caused significant or chronic problems for you:

**EYES**

- Loss of vision.....
- Blurred or distorted vision.....
- Double vision.....
- Dryness.....
- Itching or Burning.....
- Chronic redness.....
- Eye pain or soreness.....
- Flashes or floaters.....
- Glare or light sensitivity.....
- Watering or tearing.....

**EARS, NOSE, MOUTH, THROAT**

- Allergy / hay fever.....
- Chronic sinus infection.....
- Dry mouth.....

**NEUROLOGICAL**

- Headaches or migraines.....
- Seizures.....

**BONES, JOINTS, MUSCLES.....**

**CONSTITUTIONAL**

- Fever, weight loss/gain.....

**INTEGUMENTARY (SKIN).....**

**HEMATOLOGIC**

- Bleeding problems.....

**ALLERGIC / IMMUNOLOGIC.....**

**PSYCHIATRIC.....**

**GENITOURINARY**

- Kidney, bladder, genitals.....

**ENDOCRINE**

- Thyroid or other glands.....

**RESPIRATORY**

- Asthma.....
- Emphysema.....

**CARDIOVASCULAR**

- High blood pressure.....
- Vascular disease.....

**GASTROINTESTINAL**

- Chronic diarrhea or constipation...

If you checked any of the above conditions or have a condition not listed, please explain.

\_\_\_\_\_

\_\_\_\_\_  
Dr. Signature

\_\_\_\_\_  
Date

I have reviewed this form and noted changes from my previous

visit on \_\_\_\_\_ Pt. Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Dr. Signature

\_\_\_\_\_  
Date