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 ☐other: _____

Insurance Information

VISION Insurance: _____ Subscriber I.D.# _____

Subscriber's Name _____ Date of Birth _____ Relationship _____

MEDICAL Insurance: _____ 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 ☐Driving ☐Other: _____ How old is your current pair of glasses? _____

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

【Do you need a contact lens exam today? ☐Yes ☐No 】

Contact lens fitting fee starts at $95 addition to your yearly comprehensive exam and may increase depending on each patient's prescription and needs. If you need a contact lens prescription, you must have a Contact lens fitting done within 30 days of your comprehensive exam.

Have you ever tried contact lenses? ☐Yes ☐No If yes, what type of contact lenses? _____

Do you currently wear contact lenses? ☐Yes ☐No

We do not take any responsibility for contact lenses purchased outside this office.

I have read and agree to the above policies and conditions:

Responsible Party Signature: _____ Date: _____

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		Yourself	Family
Blurred Vision - Distance	☐Yes ☐No	Glaucoma	☐Yes ☐No	☐Yes ☐No
Blurred Vision - Near	☐Yes ☐No	Cataract	☐Yes ☐No	☐Yes ☐No
Eye Injury	☐Yes ☐No	Lazy Eyes	☐Yes ☐No	☐Yes ☐No
Itching Eyes	☐Yes ☐No	Crossed/Turned Eyes	☐Yes ☐No	☐Yes ☐No
Watering Eyes	☐Yes ☐No	Vision Poor	☐Yes ☐No	☐Yes ☐No
Eye Pain or Soreness	☐Yes ☐No	Iritis/Uveitis	☐Yes ☐No	☐Yes ☐No
Foreign Body Sensation	☐Yes ☐No	Ptosis	☐Yes ☐No	☐Yes ☐No
Seeing Flashes/Floaters	☐Yes ☐No	Night Vision Poor	☐Yes ☐No	☐Yes ☐No
Eye Strain	☐Yes ☐No	Loss of Side Vision	☐Yes ☐No	☐Yes ☐No
Discharge from Eyes	☐Yes ☐No	Temporary Loss of Vision	☐Yes ☐No	☐Yes ☐No
Distorted Vision/Halos	☐Yes ☐No	Color Vision Poor	☐Yes ☐No	☐Yes ☐No
Light Sensitivity	☐Yes ☐No	Loss of Vision	☐Yes ☐No	☐Yes ☐No
Double Vision	☐Yes ☐No	Nystagmus	☐Yes ☐No	☐Yes ☐No
Dry Eyes	☐Yes ☐No	Macular Degeneration	☐Yes ☐No	☐Yes ☐No
Red Eyes	☐Yes ☐No	Corneal Abrasions	☐Yes ☐No	☐Yes ☐No
Sties of Chalazion	☐Yes ☐No	Retinal Detachment	☐Yes ☐No	☐Yes ☐No
Dizzy Spells	☐Yes ☐No	Retinal Disease	☐Yes ☐No	☐Yes ☐No
Twitching Eyelid	☐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		Yourself	Family
Migraine Headache	☐Yes ☐No	☐Yes ☐No	Cancer	☐Yes ☐No	☐Yes ☐No
Asthma	☐Yes ☐No	☐Yes ☐No	Hepatitis (type _____)	☐Yes ☐No	☐Yes ☐No
Hay Fever	☐Yes ☐No	☐Yes ☐No	Skin Condition	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No	Muscular, Skeletal Systems	☐Yes ☐No	☐Yes ☐No
Cholesterol	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No	☐Yes ☐No
Hemic Lymphatic Disease	☐Yes ☐No	☐Yes ☐No	Thyroid Conditions	☐Yes ☐No	☐Yes ☐No
Heart Condition	☐Yes ☐No	☐Yes ☐No	Pacemaker	☐Yes ☐No	☐Yes ☐No
Kidney Disease	☐Yes ☐No	☐Yes ☐No	Psychiatric	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No	Shingles	☐Yes ☐No	☐Yes ☐No
Respiratory System	☐Yes ☐No	☐Yes ☐No	AIDS/HIV	☐Yes ☐No	☐Yes ☐No
Gastrointestinal Disorders	☐Yes ☐No	☐Yes ☐No	Drug Sensitivity	☐Yes ☐No	☐Yes ☐No