Vision Care Associates, P.C.

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to meeting your eye care needs with professional vision care.

A PATIENT INFO

Today's Date _____ /_____ /_____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

SS # _____ / _____ / _____

Phone # _____ Work Phone _____

Sex ☐ M ☐ F Birthdate _____ / _____ / _____

Occupation _____

Patient Employer/School _____

Employer/School Phone (_____) _____

B INSURANCE

Who is reponsible for this account? _____

Phone # _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

C EYE HEALTH HISTORY

Optometrist's name _____

Date of last visit _____ /_____ /_____

Date of last eye exam _____ /_____ /_____

Do you wear glasses ☐ Yes ☐ No

☐ All the Time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

If yes, how old is your present pair of lenses? _____

Do you wear contacts? ☐ Yes ☐ No

If yes, how old is your present pair of lenses? _____

Are they comfortable? ☐ Yes ☐ No

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other

Brand _____ Wearing Schedule _____

Replacement Schedule _____

Solutions Used _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

_____

_____

Are you pregnant and/or nursing? ☐ Yes ☐ No

D MEDICAL HISTORY

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: _____

_____

_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition			RELATIONSHIP TO YOU	Disease/Condition			RELATIONSHIP TO YOU
Blindness	☐ Yes	☐ No		Diabetes	☐ Yes	☐ No	
Cataract	☐ Yes	☐ No		Heart Disease	☐ Yes	☐ No	
Crossed Eyes	☐ Yes	☐ No		High Blood Pressure	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No		Kidney Disease	☐ Yes	☐ No	
Macular Degeneration	☐ Yes	☐ No		Lupus	☐ Yes	☐ No	
Retinal Detachment/Disease	☐ Yes	☐ No		Thyroid Disease	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No		Other	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No					

List any medications you take (including eye drops, oral contraceptives, aspirin, over the counter medications, and home remedies):

_____

_____

_____

List your allergies:

_____

_____

_____

-OVER-

E SOCIAL HISTORY

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

☐ Yes, I would prefer to discuss my social history with the doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe: _____

_____

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: _____

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

F SYSTEM HISTORY

Physician's Name _____ Physician's Phone _____ Last Medical Exam _____

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

_____

_____

Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL			
Fever, weight gain/loss	☐ Yes	☐ No	☐ ?
UTEGUMANTARY (Skin)	☐ Yes	☐ No	☐ ?
NEUROLOGICAL			
Headaches	☐ Yes	☐ No	☐ ?
Migraines	☐ Yes	☐ No	☐ ?
Seizures	☐ Yes	☐ No	☐ ?
EYES			
Loss of Vision	☐ Yes	☐ No	☐ ?
Blurred Vision	☐ Yes	☐ No	☐ ?
Distorted Vision/Halos	☐ Yes	☐ No	☐ ?
Loss of Side Vision	☐ Yes	☐ No	☐ ?
Double Vision	☐ Yes	☐ No	☐ ?
Dryness	☐ Yes	☐ No	☐ ?
Mucous Discharge	☐ Yes	☐ No	☐ ?
Redness	☐ Yes	☐ No	☐ ?
Sandy or Gritty Feeling	☐ Yes	☐ No	☐ ?
Itching	☐ Yes	☐ No	☐ ?
Burning	☐ Yes	☐ No	☐ ?
Foreign Body Sensation	☐ Yes	☐ No	☐ ?
Excess Tearing/Watering	☐ Yes	☐ No	☐ ?
Glare/Light Sensitivity	☐ Yes	☐ No	☐ ?
Eye Pain or Soreness	☐ Yes	☐ No	☐ ?
Chronic Infection of Eye or Lid	☐ Yes	☐ No	☐ ?
Styes of Chalazion	☐ Yes	☐ No	☐ ?
Flashes/Floaters in Vision	☐ Yes	☐ No	☐ ?
Tired Eyes	☐ Yes	☐ No	☐ ?
ENDOCRINE			
Thyroid/Other Glands	☐ Yes	☐ No	☐ ?

EAR, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐ Yes	☐ No	☐ ?
Sinus Congestion	☐ Yes	☐ No	☐ ?
Runny Nose	☐ Yes	☐ No	☐ ?
Post Nasal Drip	☐ Yes	☐ No	☐ ?
Chronic Cough	☐ Yes	☐ No	☐ ?
RESPIRATORY			
Asthma	☐ Yes	☐ No	☐ ?
Chronic Bronchitis	☐ Yes	☐ No	☐ ?
Emphysema	☐ Yes	☐ No	☐ ?
VASCULAR/CARDIOVASCULAR			
Diabetes	☐ Yes	☐ No	☐ ?
Heart Pain	☐ Yes	☐ No	☐ ?
High Blood Pressure	☐ Yes	☐ No	☐ ?
Vascular Disease	☐ Yes	☐ No	☐ ?
GASTROINTESTINAL			
Diarrhea	☐ Yes	☐ No	☐ ?
Constipation	☐ Yes	☐ No	☐ ?
GENITOURINARY			
Genitals/Kidney/Bladder	☐ Yes	☐ No	☐ ?
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐ Yes	☐ No	☐ ?
Muscle Pain	☐ Yes	☐ No	☐ ?
Joint Pain	☐ Yes	☐ No	☐ ?
LYMPHATIC/HEMATOLOGIC			
Anemia	☐ Yes	☐ No	☐ ?
Bleeding Problems	☐ Yes	☐ No	☐ ?
ALLERGIC/IMMUNOLOGIC	☐ Yes	☐ No	☐ ?
PSYCHIATRIC	☐ Yes	☐ No	☐ ?

If you answered YES to any of the above or have a condition not listed, please explain & list medications: _____

_____

_____

_____

I request that payment of authorized Medicare benefits or other insurance payments on my behalf be made payable to Vision Care Associates. I understand that some or all of the services I am receiving may not be a covered benefit by my insurance and I agree to be repsonsible for these services.

_____ Patient's Signature

_____ / _____ / _____ Date

_____ Doctor's Signature