

PATIENT INFORMATION

Thank you for choosing Vision Care Consultants for your eye care needs. Please complete BOTH SIDES of this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name _____ Date _____ Patient No. _____
FIRST MI LAST
Address _____ City _____ State _____ Zip _____
Birth date _____ Social Security #: _____ Home phone #: _____
Work phone #: _____ Cell Phone#: _____ E-mail: _____
Nickname: _____ Do you prefer to receive calls at: Home Work Either
Are you: Minor Married Divorced Widowed Single Separated
Please list household family members: _____
You or your parent's employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Workplace _____ Work phone # _____
If you are a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Birth date _____
Relationship to patient _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work phone # _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions and list the relationship of the family member to you:

Blindness _____ Cataract _____ Crossed eyes _____
 Glaucoma _____ Macular degeneration _____ Retinal Disease _____
 Arthritis _____ Cancer _____ Diabetes _____
 Heart Disease _____ High Blood Pressure _____ Kidney Disease _____
 Lupus _____ Thyroid Disease _____ Other? _____

MEDICAL HISTORY

Do you have any allergies to medications? no yes If yes, please explain: _____

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

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

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 or nursing? no yes
Visual correction: glasses How old is current pair? _____ contact lenses How old is current pair of lenses? _____
Type of contact lenses? Rigid Soft Extended Wear Other Are they comfortable? yes no
Would you like new contact lenses today? yes no Would you like new glasses today? yes no

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

SOCIAL HISTORY

This information is kept strictly confidential. However, if you prefer to discuss this directly with the doctor please check the following box.

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you or have you used tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you or have you used illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Chlamydia None

What hobbies or sports do you participate in? _____

Do you work at a computer or video display terminal? _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following systems: (If YES, please explain)

SYSTEM	NO	YES	EXPLAIN
Constitutional: (fever, weight loss / gain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary: (skin)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological: (headaches, migraines, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes:			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness / Burning / Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain / Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes / Halos / Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat, Mouth:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory: (asthma, chronic bronchitis, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular/Cardiovascular: (i.e. high blood pressure, diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal: (diarrhea, constipation)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary: (genitals, kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones / Joints / Muscles: (arthritis, muscle or joint pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic / Hematologic: (anemia, bleeding problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine: (thyroid / other gland)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic / Immunologic:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric:	<input type="checkbox"/>	<input type="checkbox"/>	_____

I certify that I have read and answered the above questions to the best of my knowledge. I authorize the eye doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or Vision Care Consultants any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I acknowledge that I have received a notice of privacy from Vision Care Consultants.

PATIENT'S SIGNATURE

DATE

DOCTOR'S SIGNATURE

DATE