

WELCOME TO OUR OFFICE

Opticare Vision

Name: Last _____ First _____ M.I. _____ Salutation _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Age _____ Home Phone: _____ Business Phone: _____
 SS#: _____ E-Mail Address: _____
 Employer: _____ Occupation: _____

How were you referred to our office?

- Friend or Family Member: _____
 Insurance Company
 Television
 Family Doctor _____
 Received Mailing
 Newspaper
 Ophthalmologist _____
 Internet
 Other _____

Please list all insurances, vision and medical. Please bring all insurance cards with you to your appointment.

PRIMARY INSURANCE INFO.	SECONDARY INSURANCE INFO.
Ins. Co. Name:	Ins. Co. Name:
Address:	Address:
Insured's Name:	Insured's Name:
Identification Number:	Identification Number:
Group #:	Group#:
Insured's D.O.B.:	Insured's D.O.B.:
Insured's SS#:	Insured's SS#:
Patient Relation to Insured:	Patient Relation to Insured:

EYEGLOSS HISTORY

Do you wear glasses? Yes No
 Full Time
 Part Time
 Distance
 Near

Glasses owned: Single Vision
 Bifocals
 Safety Glasses
 Backup Glasses
 Progressive
 Trifocals
 Sports Glasses
 Other...

Computer used: Yes No
 Hours per day: _____
 Distance from computer: _____

Do you have problems with glare?..... Yes No

Do you have problems with night vision?..... Yes No

Are you allergic to Nickel (eg; jewelry or eyeglass frames discoloring your skin)?..... Yes No

If you currently wear eyeglasses, are there certain times when you would rather not?..... Yes No
 (eg. Sports, business presentations, social occasions, etc.)

If you currently wear eyeglasses, does your spare pair have your correct prescription? Yes No

Do your sunglasses have UV (ultra-violet) protection?..... Yes No

Are your sunglasses your current prescription?..... Yes No

CONTACT LENS HISTORY

Do you currently wear contact lenses?..... Yes No

Have you ever tried to wear contact lenses? Yes No
 Reason for stopping: _____

Are you interested in changing or enhancing your eye color?..... Yes No

If you currently wear contact lenses, do your backup eyeglasses have your correct prescription?..... Yes No

Answer the questions below only if you currently wear contact lenses:

- What type or brand of contacts do you wear? _____
- How old are your current lenses? _____
 - How often do you replace or dispose of your contact lenses? _____
 - What brand of solution do your lenses soak in overnight? _____
 - What is your typical wearing schedule? _____ Hours/day _____ Days/week
 - Are you having any problems with your current contact lenses? Yes No

Would you like to be evaluated for refractive laser surgery? Yes No

Would you like to be evaluated for a NON-surgical method to correct your vision? Yes No

Date of last Eye Exam:_____ Where did you get your last eye exam?_____

Date of last Physical Exam:_____ Name of Primary Care Physician:_____

MEDICAL HISTORY

EYE HISTORY: With vision correction being used, do you suffer from any of the following?

- | | | | | | |
|-----------------------------|--|---------------------------|--|---------------------|--|
| Distance vision blur | <input type="radio"/> Yes <input type="radio"/> No | Seeing flashes | <input type="radio"/> Yes <input type="radio"/> No | Dry eyes | <input type="radio"/> Yes <input type="radio"/> No |
| Near vision blur | <input type="radio"/> Yes <input type="radio"/> No | Distorted vision (haloes) | <input type="radio"/> Yes <input type="radio"/> No | Itching | <input type="radio"/> Yes <input type="radio"/> No |
| Middle distance vision blur | <input type="radio"/> Yes <input type="radio"/> No | Glare / Light sensitivity | <input type="radio"/> Yes <input type="radio"/> No | Red eyes | <input type="radio"/> Yes <input type="radio"/> No |
| Double vision | <input type="radio"/> Yes <input type="radio"/> No | Loss of side vision | <input type="radio"/> Yes <input type="radio"/> No | Eye pain / soreness | <input type="radio"/> Yes <input type="radio"/> No |
| Headaches | <input type="radio"/> Yes <input type="radio"/> No | Crossed eyes | <input type="radio"/> Yes <input type="radio"/> No | Mucous discharge | <input type="radio"/> Yes <input type="radio"/> No |

REVIEW OF SYSTEMS: Many diseases of the body have grave eye health consequences. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

<i>Do you currently have any of the following problems?</i>	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue.....	<input type="radio"/>	<input type="radio"/>	_____
Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat).....	<input type="radio"/>	<input type="radio"/>	_____
Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)...	<input type="radio"/>	<input type="radio"/>	_____
Respiratory problems (eg. Shortness of breath, wheezing, coughing)	<input type="radio"/>	<input type="radio"/>	_____
Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting).....	<input type="radio"/>	<input type="radio"/>	_____
Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems).....	<input type="radio"/>	<input type="radio"/>	_____
Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints).....	<input type="radio"/>	<input type="radio"/>	_____
Skin problems (eg. Rashes, excessive dryness, growths or lumps).....	<input type="radio"/>	<input type="radio"/>	_____
Neurological problems (eg. Numbness, weakness, headaches, "blackouts").....	<input type="radio"/>	<input type="radio"/>	_____
Psychiatric problems (eg. Depression, anxiety).....	<input type="radio"/>	<input type="radio"/>	_____
Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time).....	<input type="radio"/>	<input type="radio"/>	_____
Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands).....	<input type="radio"/>	<input type="radio"/>	_____
Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens).....	<input type="radio"/>	<input type="radio"/>	_____

Have you ever been treated for any medical conditions? (eg. Diabetes, high blood pressure, arthritis, etc.)?.... Yes No
If YES, please explain._____

Have you ever had any eye disease? (eg. Glaucoma, cataract, wandering or "lazy" eye, retinal detachment)? Yes No
If YES, please explain._____

Have you ever had any surgery or been hospitalized?..... Yes No
If YES, please provide date and reason._____

Do you take any medications?..... Yes No
If YES, please list._____

Do you have any food or drug allergies?..... Yes No
If YES, please list._____

FAMILY HISTORY: Do any MEDICAL or EYE diseases run in your family (*BLOOD relatives*) (eg. Diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)?..... Yes No

If YES, please specify:_____

SOCIAL HISTORY:

- | | | | | | |
|-----------------------|------------------------------|------------------------------------|----------------------------------|----------------------------------|----------------------------------|
| Do you drink alcohol? | <input type="radio"/> No | <input type="radio"/> Occasionally | <input type="radio"/> 1 /day | <input type="radio"/> 2-3/day | <input type="radio"/> 4+/day |
| Do you smoke? | <input type="radio"/> No | <input type="radio"/> Occasionally | <input type="radio"/> _ pack/day | <input type="radio"/> 1 pack/day | <input type="radio"/> 1+pack/day |
| Marital Status | <input type="radio"/> Single | <input type="radio"/> Married | <input type="radio"/> other | | |