# 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: ____________ Your preferred contact: ❑ Home ❑ Work ❑ Cell ❑ Email ❑ Any

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Primary Language ____________ Race ____________ Ethnicity ____________

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

**CONTINUED**

# 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) | ❑ | ❑ | |
| Integumentary: (skin) | ❑ | ❑ | |
| Neurological: (headaches, migraines, seizures) | ❑ | ❑ | |
| Eyes: | | | |
| Loss of Vision | ❑ | ❑ | |
| Blurred Vision | ❑ | ❑ | |
| Dryness / Burning / Sandy or Gritty Feeling | ❑ | ❑ | |
| Mucous Discharge | ❑ | ❑ | |
| Redness | ❑ | ❑ | |
| Itching | ❑ | ❑ | |
| Eye Pain / Foreign Body Sensation | ❑ | ❑ | |
| Excess Tearing / Watering | ❑ | ❑ | |
| Glare / Light Sensitivity | ❑ | ❑ | |
| Flashes / Halos / Double Vision | ❑ | ❑ | |
| Ears, Nose, Throat, Mouth: | ❑ | ❑ | |
| Respiratory: (asthma, chronic bronchitis, emphysema) | ❑ | ❑ | |
| Vascular/Cardiovascular: (i.e. high blood pressure, diabetes) | ❑ | ❑ | |
| Gastrointestinal: (diarrhea, constipation) | ❑ | ❑ | |
| Genitourinary: (genitals, kidney, bladder) | ❑ | ❑ | |
| Bones / Joints / Muscles: (arthritis, muscle or joint pain) | ❑ | ❑ | |
| Lymphatic / Hematologic: (anemia, bleeding problems) | ❑ | ❑ | |
| Endocrine: (thyroid / other gland) | ❑ | ❑ | |
| Allergic / Immunologic: | ❑ | ❑ | |
| Psychiatric: | ❑ | ❑ | |

***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 |
|---|---|---|---|
| | | | |