MissionVision

Welcome to our office. Please fill out the following information.

Patient Information

Name (Last,First,MI) _____

Nickname _____ DOB _____/_____/_____ Age _____ Male/Female (please circle)

Address (street,city) _____(state) _____(zip)_____

Cell Phone _____-_____ Home Phone _____-_____ Other Phone _____-_____

Email _____

Others living at home or on same insurance plan

Name _____ Age_____ Name_____ Age_____

Name _____ Age_____ Name_____ Age_____

Occupation _____ Employer _____

How did you hear about Mission Vision? _____

Ocular History/Surgery (please circle all that apply)

Cataract Crossed Eye Diabetic Retinopathy Dry Eye Flashes/Floaters Foreign Body
Glaucoma Headaches Infection Itchy Eyes LASIK/PRK Macular Degeneration
Retinal Detachment Tearing Trauma

Eye Medications _____

Last Eye Exam Date _____ Eye Doctor _____

Primary Vision correction (glasses, contact lenses, OTC readers, none) Back up glasses (Y/N)

Brand of Contact Lenses worn _____ Cleaner _____ Wear Time _____ Disposal _____

Family Ocular history (please circle all that apply and list relative next to condition)

Glaucoma Cataracts Macular Degeneration Retinal detachment Cross eye Blindness

Patient Medical History

Diabetes (self/family – please list relative) _____
For self: Year diagnosed _____ Blood Sugar _____ HbA1c _____
Hypertension (self/family – please list relative) _____
High Cholesterol (self/family – please list relative) _____
Cardiovascular (self/family – please list relative) _____
Cancer (self/family – please list relative) _____

More on back. Turn over ⇒

Review of Systems (please check all that apply)

General	Genital/Kidney/Bladder ☐	Psychiatric
Fatigue ☐	Muscle/Bones/Joints/Arthritis ☐	ADHD ☐
Fever ☐	Gastrointestinal	Anxiety ☐
Ear, nose, throat	Crohns ☐	Depression
Chronic cough ☐	IBS ☐	Endocrine
Dry mouth ☐	Skin	T1 Diabetes ☐
Runny nose ☐	Eczema ☐	T2 Diabetes ☐
Congestion ☐	Itching ☐	Hyperthyroid ☐
Cardiovascular	Rosacea ☐	Hypothyroid ☐
Heart disease ☐	Neurological	Blood/Lymph
Vascular disease ☐	Headaches ☐	Anemia ☐
Respiratory	Migraines ☐	Bleeding disorders ☐
Asthma ☐	MS ☐	Allergies ☐
Bronchitis ☐	Numbness ☐	
Emphysema ☐	Seizures ☐	
COPD ☐		

Medications/Allergies/Other History

Medications/Vitamins/OTC

_____

_____

_____

Allergies to Medications _____

Primary Care Physician _____ Last visit _____

Specialist _____

Injuries/Surgeries/Hospitalizations _____

Pregnant or Nursing (please circle if applicable)

Social History

Hobbies _____

Smoking (Y/N) Type _____ How long _____

Alcohol (Y/N) Frequency _____

Illegal Drugs (Y/N) Type _____

Sexually Transmitted Disease (Y/N) Type _____