WELCOME TO LIFETIME VISION!

Mr./ Mrs./ Ms._____ _____ _____
First Name MI Last Name

Address: _____

DOB:_____ SSN Last Four:_____ Sex: Male / Female

Phone Number: _____ Cell / Home / Work Email Address:_____

Primary Care Physician: _____
Name Address Phone

Health Insurance: _____
Plan Name Subscriber ID

Guarantor's Name: _____

Vision Plan: _____
Plan Name Member ID

REVIEW OF SYSTEMS

Constitution
- ❑ Developmental disabilities
- ❑ Cancer
- ❑ Fatigue Syndrome
- ❑ Other

ENT
- ❑ Hearing Loss
- ❑ Sinusitis
- ❑ Dry mouth
- ❑ Laryngitis
- ❑ Other

Neurological
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Cerebral Palsy
- ❑ Tumor
- ❑ Stroke/CVA
- ❑ Migraine
- ❑ Autism Spectrum Disorder
- ❑ Other

Psychological
- ❑ Depression
- ❑ Attention deficit
- ❑ Anxiety disorder
- ❑ Bipolar disorder
- ❑ Other

Cardiovascular
- ❑ Hypertension
- ❑ Stroke/CVA
- ❑ Heart disease
- ❑ Vascular disease
- ❑ Congenital heart failure
- ❑ Other

Respiratory
- ❑ Cigarette smoker
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic obstruction
- ❑ Sleep Apnea
- ❑ Other

GI
- ❑ Crohns
- ❑ Colitis
- ❑ Ulcer
- ❑ Acid Reflux
- ❑ Celiac disease
- ❑ Other

Genitourinary
- ❑ Kidney disease
- ❑ Prostate disease/cancer
- ❑ STD-herpetic/chlamydia
- ❑ Benign prostate hypertrophy
- ❑ Pregnant
- ❑ Nursing
- ❑ Herpes
- ❑ Chlamydia
- ❑ Other

Muscular / Skeletal
- ❑ Arthritis
- ❑ Osteoarthritis
- ❑ Fibromyalgia
- ❑ Muscular Dystrophy
- ❑ Ankylosing Spondylitis
- ❑ Osteoporosis
- ❑ Gout
- ❑ Other

Integumentary
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Herpes Simplex/cold sores
- ❑ Herpes Zoster/Shingles
- ❑ Other

Endocrine
- ❑ Type 2 Diabetes Mellitus
- ❑ Type 1 Diabetes Mellitus
- ❑ Thyroid dysfunction
- ❑ Hormone dysfunction
- ❑ Other

Hematological / Lymph
- ❑ Anemia
- ❑ Large volume blood loss
- ❑ Ulcer
- ❑ Hypercholesterolemia
- ❑ Other

Allergy / Immunological
- ❑ Drug allergies
- ❑ Environmental allergies
- ❑ Rheumatoid Arthritis
- ❑ Lupus
- ❑ Sjogren's Syndrome
- ❑ Other

OTHER NOT LISTED:

_____

_____

_____

MEDICATIONS Please include over the counter medications

_____

_____

_____

ALLERGIES Please include non-medication related allergies

❑ Penicillin ❑ Latex ❑ Other _____

PAST OCULAR HISTORY

❑ Glaucoma
❑ Glaucoma suspect
❑ Cataract
❑ Age-related macular degeneration
❑ Surgery
❑ Patching
❑ Inflammatory disorder
❑ Strabismus
❑ Amblyopia
❑ Retinal degeneration
❑ Retinal hole
❑ Retinal detachment
❑ Keratoconus
❑ Injury
❑ Dry eye
❑ Nystagmus
❑ Other _____

SOCIAL HISTORY

Drinking: Yes / No, Never If yes, amount: _____

Tobacco Use: Yes / No, Never If yes, amount: _____ everyday / someday / former

Hobbies: _____ Occupation: _____

FAMILY MEDICAL HISTORY

Check all that apply	Father	Mother	Brother	Sister	Son	Daughter
Family Hx of Cancer						
Family Hx of Diabetic Mellitus Type 2						
Family Hx of Diabetic Mellitus Type 1						
Family Hx of Hypertension						
Family Hx of Hyperthyroidism						
Family Hx of Hypothyroidism						

FAMILY OCULAR HISTORY

Check all that apply	Father	Mother	Brother	Sister	Son	Daughter
Family Hx of Macular Degeneration						
Family Hx of Cataracts						
Family Hx of Glaucoma						

CONTACT LENS HISTORY

Current wearer: Yes / No / No, but I am interested

If YES, Brand: _____ Contact lens Solution used: _____

Average daily wear time (hours): _____ Average Replacement period: __Daily __Bi-weekly __Monthly

Signature*: _____ Date: _____

* If under 18, Signature of responsible party. Print your name: _____