

MEDICAL HISTORY **NAME** _____ **DATE** _____

Vision plans cover "routine" eye exams. Some medical plans will only cover the visit if there is a medical reason for the visit, such as loss of vision, eye redness, eye discomfort, dry eyes, glaucoma, cataracts, floating spots, etc. If we are able to use your medical insurance to cover the visit, you will have to pay both the specialist copay as listed on your insurance card *and* the refraction fee (refraction is the part of the exam that determines your eyeglass prescription) We will help as much as possible to determine coverage, but ultimately, you are responsible for referrals and fees not covered or applied to your deductible.

For current contact lens wearers or those who want to be fit for contact lenses, there is an additional fee (other than the eye exam fee) for the evaluation and measurements necessary to determine the health, safety and proper lens selection for the eyes. This includes any wearing instructions, starter solutions/kits, and any follow-up visits to complete the fitting/evaluation, as determined by the doctor. These measurements and lens needs can change and will need to be re-evaluated over time.

Please initial that you understand the above statements: _____

Are you interested in purchasing new glasses today? Yes _____ No _____

Do you currently wear contact lenses? Yes _____ No _____ Are you interested in contact lenses? Yes _____ No _____

Are you interested in Laser Vision Correction? Yes _____ No _____

REASON for VISIT: How can we help you today? Please tell us below the main eye/vision problem that you are having:

Please circle your response (in bold):

Is the problem with the **RIGHT**, **LEFT**, **BOTH** eyes? Is it worse at **DISTANCE**, **CLOSE-UP**, or **BOTH**?

Is the problem **POOR VISION** or **DISCOMFORT**? Did it happen **SUDDENLY** or **GRADUALLY**?

Is the problem **MILD**, **MODERATE**, or **SEVERE**? Is the problem **CONSTANT** or **INTERMITTENT**?

Is the problem **RECENT** or **LONG TERM**?

Are there any associated symptoms? _____

Does anything alleviate the symptoms? _____

Review of Systems: Do you or any family member have or ever had the following? (Please check if "Yes")

	You	Family		You	Family
Allergies	_____	_____	Headache	_____	_____
Arthritis	_____	_____	Heart Disease	_____	_____
Asthma	_____	_____	High Blood Pressure	_____	_____
Autoimmune Disorder	_____	_____	High Cholesterol	_____	_____
Cancer	_____	_____	Lung Problems	_____	_____
Diabetes	_____	_____	Neurological Problems	_____	_____
Gastrointestinal Disease	_____	_____	Genito/Urinary	_____	_____
Psychiatric Disorders	_____	_____	Skin Conditions	_____	_____
Thyroid Disease	_____	_____	Eye/Head Injury	_____	_____
Glaucoma	_____	_____	Eye Surgery	_____	_____
Lazy Eye	_____	_____	Other Eye Disease	_____	_____

Females: Are you pregnant? Yes _____ No _____ How many months? _____ Are you nursing? Yes _____ No _____

Please list any medications you are taking now: _____

Are you a: Current Smoker _____ Former Smoker _____ Quit, how many years ago? _____ Never Smoked _____

Alcohol use: Socially _____ Daily use _____ Never _____

Any drug allergies? No _____ Yes _____ Please list: _____

If there are no changes to previous information already filled out above, please initial and date below:

Initial & date _____