ADVANCED VISION CARE

PLEASE PRESENT THIS INFORMATION ALONG WITH INSURANCE CARDS AND PHOTO IDENTIFICATION UPON OFFICE ARRIVAL

Name: _____________________________ Nickname: _______________ Gender: M / F

Date of Birth: ________/________/_________ Social Security # ______-______-________

Address: ______________________________ City: ____________________ State: ______ Zip: _________

Phone: Home: (___)_______________ Cell: (___)_________________ Work: (___)____________

May we send text messages to your cell? Y / N Email: ___________________________________

Preferred method of contact ? CALL (Home / Cell / Work) / TEXT / EMAIL

Occupation: ____________________________ Employer: __________________________________

Employment Status: Retired: _______ Full-Time: ______ Part-Time: ______ Unemployed: _____

Marital Status: S / M / D / W Children’s Names & Ages:______________________________

Spouse: ________________ Spouse's DOB: _____/_____/_____ Spouse's SSN: _____-_____-_________

Spouse's Employer: __________________________ Spouse's Employer Phone: (___)______________

If a patient is a minor, please enter responsible party information: (Note we do not bill absent parents, the adult presenting the minor is the responsible party.)

Responsible Party: _________________________ Employer: _______________

Responsible Party's DOB: ____________________ Responsible Party's SSN: ____-____-______

Policy Holder (**if different from responsible party**): _______________________________________

Policy Holder's DOB: _____/_____/_______ Policy Holder's SSN: ______/______/_______

Employer of Policy Holder: ________________________ Work Phone: (____)__________________

Patient's Relationship to Policy Holder: ____

May we share patient information with another person not listed above? Y / N

If yes, whom? ____

Patient Name: (Printed) ___________________________________

Patient/Guardian Signature: _____________________________________ Date: ____/___/_______

SOCIAL HISTORY

Do you use tobacco products? Y / N   Drink alcohol? Y / N Use any illegal or recreational drugs? Y / N

If yes to any of above, type/amount/how long? ____

OCULAR HISTORY

How long since last eye exam ?______________   Doctor who performed exam: ______________________

Wear glasses?   Y / N   If so, how old is current pair?_______   Wear contact lenses? Y / N

If yes, what type (soft, gas perm, etc) & brand? ____________________   Sleep in them? Y / N / Occasionally

If you don't wear contacts, are you interested in them? Y / N   Interested in refractive surgery? Y / N

Please specify if you personally or a family member has a history of the following:

EYES:	YES	NO	FAMILY, WHO?	EYES:	YES	NO	FAMILY, WHO?
Cataracts	[ ]	[ ]	[ ] _________	Tearing	[ ]	[ ]	[ ] _________
Macular Degeneration	[ ]	[ ]	[ ] _________	Discharge	[ ]	[ ]	[ ] _________
Glaucoma	[ ]	[ ]	[ ] _________	Blurred Vision	[ ]	[ ]	[ ] _________
Diabetic Retinopathy	[ ]	[ ]	[ ] _________	Eyestrain	[ ]	[ ]	[ ] _________
Dry Eye	[ ]	[ ]	[ ] _________	Eye Pain	[ ]	[ ]	[ ] _________
Eye Infection/Allergy	[ ]	[ ]	[ ] _________	Light Sensitivity	[ ]	[ ]	[ ] _________
Floaters/Flashes	[ ]	[ ]	[ ] _________	Headache	[ ]	[ ]	[ ] _________
Iritis/Uveitis	[ ]	[ ]	[ ] _________	Poor Night Vision	[ ]	[ ]	[ ] _________
Retina Defects	[ ]	[ ]	[ ] _________	Night Glare	[ ]	[ ]	[ ] _________
Redness	[ ]	[ ]	[ ] _________	Double Vision	[ ]	[ ]	[ ] _________
Buring	[ ]	[ ]	[ ] _________	Total Vision Loss	[ ]	[ ]	[ ] _________
Itching	[ ]	[ ]	[ ] _________	Lazy Eye	[ ]	[ ]	[ ] _________
Color Blindness	[ ]	[ ]	[ ] _________	Nystagmus	[ ]	[ ]	[ ] _________

Primary Care Physician: _______________________   Location/City:_____________________________

Specialty Physician (e.g. Endocrinologist): ______________________   Location: _____________________

Pharmacy: _______________________________________   Location: __________________________________

Please list ALL medications you are currently taking along with dosage, route, and reason (include OTC and eye drops):

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Medication: ______________________________ Dosage: _______________ Route: _________________

Do you have any allergies to medications?   Y / N

If yes, please list & explain type of reaction: ____

Please list all major surgeries & injuries, including dates: ____

Have you had any eye injuries, surgeries, or other significant eye problems (include dates)?

MEDICAL HISTORY

CONSTITUTIONAL	YES	NO	FAMILY, WHO?
Developmental Disabilities	( )	( )	( ) ________
Fatigue Syndrome	( )	( )	( ) ________
Cancer	( )	( )	( ) ________
Weight Flucuation	( )	( )	( ) ________
Fever/Chills	( )	( )	( ) ________
Trauma	( )	( )	( ) ________
Other ________			

EAR/NOSE/THROAT	YES	NO	FAMILY, WHO?
Hearing Loss	( )	( )	( ) ________
Sinusitis	( )	( )	( ) ________
Dry Mouth	( )	( )	( ) ________
Laryingitis	( )	( )	( ) ________
Ringing	( )	( )	( ) ________
Vertigo	( )	( )	( ) ________
Other ________			

NEUROLOGIC	YES	NO	FAMILY, WHO?
Multiple Sclerosis	( )	( )	( ) ________
Epilepsy	( )	( )	( ) ________
Cerebral Palsy	( )	( )	( ) ________
Tumor	( )	( )	( ) ________
Stroke/CVA	( )	( )	( ) ________
Migraine	( )	( )	( ) ________
Autism	( )	( )	( ) ________
Headaches	( )	( )	( ) ________
Memory Loss	( )	( )	( ) ________
Other ________			

PSYCHIATRIC	YES	NO	FAMILY, WHO?
Depression	( )	( )	( ) ________
Attention Deficit	( )	( )	( ) ________
Anxiety Disorder	( )	( )	( ) ________
Bipolar Disorder	( )	( )	( ) ________
Sleep Disorder	( )	( )	( ) ________
Other ________			

CARDIOVASCULAR	YES	NO	FAMILY, WHO?
Hypertension	( )	( )	( ) ________
Stroke/CVA	( )	( )	( ) ________
Heart Disease	( )	( )	( ) ________
Vascular Disease	( )	( )	( ) ________
Congestive Heart Failure	( )	( )	( ) ________
Other ________			

RESPIRATORY	YES	NO	FAMILY, WHO?
Cigarette Smoker	( )	( )	( ) ________
Asthma	( )	( )	( ) ________
Bronchitis	( )	( )	( ) ________
Emphysema	( )	( )	( ) ________
Chronic Obstruction	( )	( )	( ) ________
Sleep Apnea	( )	( )	( ) ________
Other ________			

GASTROINTESTINAL	YES	NO	FAMILY, WHO?
Crohn's Disease	( )	( )	( ) ________
Colitis	( )	( )	( ) ________
Ulcer	( )	( )	( ) ________
Acid Reflux	( )	( )	( ) ________
Celiac Disease	( )	( )	( ) ________
IBS/Digestive	( )	( )	( ) ________
Eating Disorder	( )	( )	( ) ________
Other ________			

GENITOURINARY	YES	NO	FAMILY,WHO?
Kidney Disease	( )	( )	( ) ________
Prostate Disease/Cancer	( )	( )	( ) ________
Pregnant	( )	( )	( ) ________
Nursing	( )	( )	( ) ________
STD	( )	( )	( ) ________
If yes list ________			
Other ________			

MUSCULOSKELETAL	YES	NO	FAMILY WHO?
Osteoarthritis	( )	( )	( ) ________
Arthritis	( )	( )	( ) ________
Fibromyalgia	( )	( )	( ) ________
Muscular Dystrophy	( )	( )	( ) ________
Ankylosing Spondylitis	( )	( )	( ) ________
Osteoporosis	( )	( )	( ) ________
Gout	( )	( )	( ) ________
Rheumatoid Arthritis	( )	( )	( ) ________
Muscle/Joint Pain	( )	( )	( ) ________

INTUGUMENTARY	YES	NO	FAMILY,WHO?
Eczema	( )	( )	( ) ________
Rosacea	( )	( )	( ) ________
Psoriasis	( )	( )	( ) ________
Herpes Simplex (Cold Sore)	( )	( )	( ) ________
Herpes Zoster (Shingles)	( )	( )	( ) ________
Cancer	( )	( )	( ) ________
Other ________			

ENDOCRINE	YES	NO	FAMILY,WHO?
Type 2 Diabetes	( )	( )	( ) ________
Type 1 Diabetes	( )	( )	( ) ________
Thyroid Dysfunction	( )	( )	( ) ________
Hormonal Dysfunction	( )	( )	( ) ________
Other ________			

BLOOD/LYMPHATIC	YES	NO	FAMILY,WHO?
Anemia	( )	( )	( ) ________
Blood Loss	( )	( )	( ) ________
Ulcer	( )	( )	( ) ________
Hypercholesteremia	( )	( )	( ) ________
Sjogren's	( )	( )	( ) ________
Leukemia	( )	( )	( ) ________
Other ________			

ALLERGIC/IMMUNE	YES	NO	FAMILY,WHO?
Drug Allergies	( )	( )	( ) ________
Enviromental Allergies	( )	( )	( ) ________
Rheumatoid Arthritis	( )	( )	( ) ________
Lupus	( )	( )	( ) ________
Sjogren's Syndrome	( )	( )	( ) ________
Food	( )	( )	( ) ________
Seasonal	( )	( )	( ) ________
Other ________			

PATIENT SIGNATURE:

____

DATE: ____________ **PHYSICIAN INITIALS** ____________