

## **Patient History**

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name Mr.	Patient ID:										
Last Name	Middle	First Name	Suffix	Preferred	DOB (mm/dd/yy)	SSN					
Patient's Address	Address	Line 2 Primary	Phone H	ome Mobile	Day/Work Phone						
City State	Zip	Country Emerge	ncy Contact		Emergency Phone						
		Demonstra		41-1							
Email		Person	esponsible for	this account							
Other person authorized to discuss health info       Name         Relationship to patient       Relationship to patient											
Sex Male Female	e Occupation/Grade			Employer/School							
Primary Physician	P.A. N.P. R.N. Middle La	st Name	Suffix	Clinic Name							
Primary Insurance			Secondary	Insurance							
Insured's Name (First Name, Middle Initial, Last Name)				Insured's Name (First Name, Middle Initial, Last Name)							
Insured's ID No Group No Insured's DOB Sex				D No Group No	Insured's DOB	Sex					
Pt Relationship to Insured	Self Spouse	Child Other	Pt Relation	iship to Insured Se	If Spouse Child	d Other					
How did you initially find our office?											
Health History Reason for toda When was your last e Past illnesses Past surgeries / Eye	ye exam? or injuries	V	/hen was your	last health exam?							
Current	eye drops										
Current m	edications										
Reactions/sensitivities	medicines										
Specifi	c allergies										

Glaze Sensitivity       Yes       No       Process Body Sensation       Yes       No       Districted roles       Yes       No         Light Sensitivity       Yes       No       Iterations       Yes       No       Dubits Vision       Yes       No         Light Sensitivity       Yes       No       Drooping Eyeid       Yes       No       Floaters of Spoid       Yes       No         Daried Syse       Yes       No       Sandy of Chicahage       Yes       No       Exercise Sensitivity       Yes       No       Exercise Sensitivity <td< th=""><th>Current Eye Symptoms</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></td<>	Current Eye Symptoms									
Light Senative       Yes       No       Intelligy       Yes       No         Treet Eyes       Yes       No       Mucous Discharge       Yes       No       Flashes of Spats       Yes       No         Dynes       Yes       No       Rechess       Yes       No       Flashes of Spats       Yes       No         Dynes       Yes       No       Rechess       Yes       No       Loss of Side Visio       Yes       No         Excess Ferraring/Watering       Yes       No       Burnd Vision Near       Yes       No       Closs of Vision       Yes       No         Eye Plan of Storeense       Yes       No       Burnd Vision Near       Yes       No       Other       Yes       No         Eye Plan of Storeense       Yes       No       Burnd Vision Near       Yes       No       Close of Vision       Yes       No         Eye Plan of Storeense       Yes       No       Burnd Vision Near       Yes       No       Close of Vision       Yes       No         Carantal       Yes       No       Burnd Vision Near       Yes       No       Close Storeense       Yes       No         Carantal       Yes       No       High Risk Medicatino	Glare Sensitivity Yes	No	Foreign Body Sensation	Yes	No	Distorted Vision (Halos)	Yes	No		
Trace type       Yes       No       Muncous Discharge       Yes       No       Producting Yusion       Yes       No         Drynes       Yes       No       Drooping Eyeldi       Yes       No       Loss of Central Yusion       Yes       No         Excess Tearing/Watering       Yes       No       Sandy or Critity Feeling       Yes       No       Loss of Central Yusion       Yes       No         Excess Tearing/Watering       Yes       No       Bitured Yusion Near       Yes       No       Loss of Central Yusion       Yes       No         Eye History       Ambycola (Lary Eye)       Yes       No       Bitured Yusion Near       Yes       No       Calce Central Yusion       Yes       No         Cataract Yes       No       Galacoma       Yes       No       Galacoma       Yes       No       Concent Pice No       No       Keatocoma       No       Keatocoma       No       Concent Pice No       Concent Pice No       No       Keatocoma       No       Concent Pice No       No       Concent Pice No       No       Keatocoma       No       Concent Pice No       No       Concent Pice No       No	Headaches Yes	No	Infection of Eye or Lid	Yes	No	Double Vision	Yes	No		
Burding       Yes       No       Doroping Eyelik       Yes       No       Placetases       Yes       No       Loss of Cartfa' Union       Yes       No         Excess Tearing/Watering       Yes       No       Burned Vision Detance       Yes       No       Loss of Side Vision       Yes       No         Eyel Asseming       Yes       No       Burned Vision Near       Yes       No       Loss of Side Vision       Yes       No         Eyel Asseming       Yes       No       Dry Eye Syndrome       Yes       No       Carsard       Yes       No       Carsard       Yes       No       Revealed Side Vision       Yes       No       Revealed Side Vision       Yes       No       Carsard       Yes       No       Revealed Side Vision       Yes       No <t< td=""><td>Light Sensitivity Yes</td><td>No</td><td></td><td>Yes</td><td>No</td><td>Flashes</td><td>Yes</td><td>No</td></t<>	Light Sensitivity Yes	No		Yes	No	Flashes	Yes	No		
Dyname       Yes       No       Loss of Central Vision       Yes       No         Excess Tearing/Watering       Yes       No       Loss of Side Vision       Yes       No         Excess Tearing/Watering       Yes       No       Biured Vision Near       Yes       No       Loss of Side Vision       Yes       No         Eye Hain or Screeness       Yes       No       Dry Eye Syndrome       Yes       No       Consol Side Vision       Yes       No         Eye Hain or Screeness       Yes       No       Dry Eye Syndrome       Yes       No       Consol Side Vision       Yes       No         Biudreess       Yes       No       Galaxona       Yes       No       Galaxona       Yes       No       Consol Side Vision       Yes       No         Cataract       Yes       No       Galaxona       Yes       No       Galaxona       Yes       No       Consol Side Vision       Yes       No         Cataract       Yes       No       Galaxona       Yes       No       Galaxona       Yes       No       Consol Side Vision       Yes       No         Cataract       Yes       No       Galaxona       Yes       No       Concasona       Yes       No <td>Tired Eyes Yes</td> <td>No</td> <td>Mucous Discharge</td> <td>Yes</td> <td>No</td> <td></td> <td>8</td> <td>=</td>	Tired Eyes Yes	No	Mucous Discharge	Yes	No		8	=		
Excess Teanng/Valency       Yes       No       Sandy or Gritty Feeling       Yes       No       Loss of Ska Vision       Yes       No         Eydel Swelling       Yes       No       Blurred Vision Near       Yes       No       Loss of Vision       Yes       No         Eydel Swelling       Yes       No       Blurred Vision Near       Yes       No       Construction       Yes       No         Eyde Fildsory       Anthyopia (Lazy Eyp)       Yes       No       Blurdevision Near       Yes       No       Retinal Detachment       Yes       No         Blindness       Yes       No       Gaucoma Suspect       Yes       No       Conservice State       No<	Burning Yes	No	Drooping Eyelid	Yes	No	-	8	=		
Evelid Swelling       Yes       No       Blurred Vision Distance       Yes       No         Eye Pain or Soreness       Yes       No       Blurred Vision Near       Yes       No         Eye Pain or Soreness       Yes       No       Blurned Vision Near       Yes       No         Anhlyppia (Lazy Eye)       Yes       No       Blurned Vision Near       Yes       No         Bindness       Yes       No       Glaucoma Suspect       Yes       No       Retinal Detachment)       Yes       No         Color Bindness       Yes       No       Glaucoma Suspect       Yes       No       Consol (Yilino)       Yes       No         Color Bindness       Yes       No       Glaucoma Suspect       Yes       No       Consol (Yelessee)       Yes       No         Color Bindness       Yes       No       Macular Degeneration       Yes       No       Consol (Yelessee)       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Macular Degeneration       Yes       No       Antely of Detactanten       Yes       No       Antely of D	Dryness Yes	No		Yes	No		8	=		
Eye Pland of Soreness       Yes       No       Burned Vision Netr       Yes       No         Eye Pland of Soreness       Yes       No       Dry Eye Syndrome       Yes       No         Eye Pland       Antblyopia (Lazy Eye)       Yes       No       Burned Vision Netr       Yes       No         Eye Pland       Bindness       Yes       No       Gaucoma       Yes       No       Retinal Detachment)       Yes       No         Color Bindness       Yes       No       Gaucoma Suspect       Yes       No       Concert Pieces       No         Color Bindness       Yes       No       Gaucoma Suspect       Yes       No       Concert Pieces       No         General Health Condition       Fever. Weight Loss Falloga, etc.       Yes       No       Macular Degeneration       Yes       No         Cardovascular (High BP etc.)       Yes       No       Macular Degeneration       Yes       No       Altergic, Immuno       Yes       No         Cardovascular (High BP etc.)       Yes       No       Macular Degeneration       Yes       No       Altergic, Immuno       Yes       No         Gastrointestinal       Yes       No       Macular Degeneration       Yes       No       No <t< td=""><td></td><td>No</td><td></td><td>Yes</td><td>No</td><td></td><td>8</td><td>=</td></t<>		No		Yes	No		8	=		
Eye History       Ambyopia (Lazz Eye)       Yes       No       Dry Eye Syndrome       Yes       No         Eye History       Ambyopia (Lazz Eye)       Yes       No       Eye History       PVD (Vitroous Detachment)       Yes       No         Infection of Eye or Lid       Yes       No       Eye History       No       Restrict Mathematication       Yes       No         Cataract       Yes       No       Glaucoma Suppert       Yes       No       Corneal Detachment)       Yes       No         Cotor Bindness       Yes       No       High Risk Medication       Yes       No       Corneal Desase       Yes       No         General Health Condition       Fever. Weight Loss, Fatigue, etc       Yes       No       Matcles, Bones, Joints issues       Yes       No       Corneal Desase       Yes       No         General Health Condition       Fever. Weight Loss, Fatigue, etc       Yes       No       Matcles, Bones, Joints issues       Yes       No       Blood (Cholesterol, Anemia, etc)       Yes       No         Cataroxity (Asitman)       Yes       No       Matcles, Bones, Joints issues       Yes       No       Analytypia (Lazy Eye)       Yes       No       Analytypia (Lazy Eye)       No       No       No       No <td< td=""><td></td><td>=</td><td></td><td>8</td><td><b>H</b></td><td></td><td></td><td>=</td></td<>		=		8	<b>H</b>			=		
Anthlyopia (Lazy Eye)       Yes       No       Dry Eye Syndrome       Yes       No         Infection of Eye or Lid       Yes       No       Eye Injuries       Yes       No         Bindness       Yes       No       Glaucoma Suspect       Yes       No       Crossed Eyes       Yes       No         Cataract       Yes       No       Glaucoma Suspect       Yes       No       Consent Eyes       No       Consent Eyes <td>Eye Pain or Soreness Yes</td> <td>No</td> <td>Blurred Vision Near</td> <td>Yes</td> <td><u>No</u></td> <td>Other</td> <td></td> <td></td>	Eye Pain or Soreness Yes	No	Blurred Vision Near	Yes	<u>No</u>	Other				
Infection of Eye or Lid       Yes       No       Eye Injuries       Yes       No       Retinal Detachment       Yes       No         Bilindness       Yes       No       Glaucoma       Yes       No       Crossed Eyes       Yes       No         Cataracity       Yes       No       Glaucoma       Yes       No       Koratoonus       Yes       No         Cator Bildnames       Yes       No       High Risk Medication       Yes       No       Correal Disease       Yes       No         Cator Bildnames       Yes       No       Macular Degeneration       Yes       No       Correal Disease       Yes       No         Fever, Weight Loss, Futgue, etc       Yes       No       Kidney, Bladder issues       Yes       No       Blod (Cholesterol, Anemia, etc)       Yes       No         Cardiovascular (High BPic), City Yes       No       No <td>Eye History</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Eye History									
Bindness       Yes       No       Glaucoma       Yes       No       Crossel Eyes       Yes       No         Cataract       Yes       No       Glaucoma       Suspect       Yes       No       Commed Disease       Yes       No         Cataract       Yes       No       High Risk Medication       Yes       No       Commed Disease       Yes       No         Cataract       Yes       No       Macular Degeneration       Yes       No       Other       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Muscles, Bones, Joints issues       Yes       No       Allergin, Immuno       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Skin (Rash, Iching, etc)       Yes       No       Allergin, Immuno       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Asciety or Depression       Yes       No       Austry or Depression       Yes       No       Kianey, Bladder issues       Yes       No       Kianey, Bladder issues       Yes       No       Allergin, Immuno       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Anxiety or Depression       Yes       No       Respirator, No       No </td <td>Amblyopia (Lazy Eye)</td> <td>No</td> <td>Dry Eye Syndrome</td> <td>Yes</td> <td>No</td> <td>PVD (Vitreous Detachment)</td> <td>Yes</td> <td>No</td>	Amblyopia (Lazy Eye)	No	Dry Eye Syndrome	Yes	No	PVD (Vitreous Detachment)	Yes	No		
Bindness       Yes       No       Glaucoma       Yes       No       Crossel Eyes       Yes       No         Cataract       Yes       No       Glaucoma       Suspect       Yes       No       Commed Disease       Yes       No         Cataract       Yes       No       High Risk Medication       Yes       No       Commed Disease       Yes       No         Cataract       Yes       No       Macular Degeneration       Yes       No       Other       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Muscles, Bones, Joints issues       Yes       No       Allergin, Immuno       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Skin (Rash, Iching, etc)       Yes       No       Allergin, Immuno       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Asciety or Depression       Yes       No       Austry or Depression       Yes       No       Kianey, Bladder issues       Yes       No       Kianey, Bladder issues       Yes       No       Allergin, Immuno       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Anxiety or Depression       Yes       No       Respirator, No       No </td <td></td> <td>No</td> <td>Eye Injuries</td> <td>Yes</td> <td>No</td> <td>Retinal Detachment</td> <td>Yes</td> <td>No</td>		No	Eye Injuries	Yes	No	Retinal Detachment	Yes	No		
Color Blindness       Yes       No       High Risk Medication       Yes       No         Diabetic Retinopathy       Yes       No       Macular Degeneration       Yes       No         General Health Condition       Pever, Weight Loss, Fatigue, etc       Yes       No       Macular Degeneration       Yes       No         General Health Condition       Pever, Weight Loss, Fatigue, etc       Yes       No       Macular Degeneration       Blood (Cholesterol, Anemia, etc)       Yes       No         Carlovascular (High PB etc.)       (Pes       No       Muscles, Bones, Joints issues       Yes       No       Anemia, etc.)       Yes       No         Respiratory (Asthma)       Yes       No       Muscles, Bones, Joints issues       Yes       No       Anemia, etc.)       Yes       No         Analysis       Yes       No       Macular Degeneration       Yes       No       Anerial Disease       Yes       No         Bindness       Yes       No       Anxiety or Depression       Yes       No       Kidney Disease       Yes       No         Bindness       Yes       No       Anxiety or Depression       Yes       No       Kidney Disease       Yes       No         Cataract(s)       Yes       No		No	Glaucoma	Yes	No	Crossed Eyes	Yes	No		
Diabelic Retinopathy       Yes       No       Other       Yes       No         General Health Condition       Fever, Weight Loss, Faligue, etc       Yes       No       Thyroid, Diabetes       Yes       No         Fever, Weight Loss, Faligue, etc       Yes       No       Macclas Degeneration       Yes       No       Blood (Cholesterol, Anemia, etc)       Yes       No         Cardiovascular (High BP etc)       Yes       No       Macclas, Bones, Joints issues       Yes       No       Blood (Cholesterol, Anemia, etc)       Yes       No         Respiratory (Asthma)       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No       Nursing       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No       Nursing       Yes       No         Genaral Lass of the statistional (Lazy Eye)       Yes       No       Macul	Cataract Yes	No	Glaucoma Suspect	Yes	No	Keratoconus	Yes	No		
Construction       Construction         General Health Condition       Forev, Weight Loss, Fatigue, etc.       Yes       No         Kidney, Bladder issues       Yes       No       Blood (Cholesterol, Anemia, etc)       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Skin (Rash, Itching, etc)       Yes       No       Allergic, Immuno       Yes       No         Gastrointestinal       Yes       No       Anxiety or Depression       Yes       No       Allergic, Immuno       Yes       No         Family History       Amblyopia (Lazy Eye)       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No         Cataract(s)       Yes       No       Artititititity       Yes       No       Lupus       Yes       No         Cataract(s)       Yes       No       Cataract(s)       Yes       No       Lupus       Yes       No         Gastrointestinal </td <td></td> <td>No</td> <td>High Risk Medication</td> <td>Yes</td> <td>No</td> <td>Corneal Disease</td> <td>Yes</td> <td>No</td>		No	High Risk Medication	Yes	No	Corneal Disease	Yes	No		
Fever, Weight Loss, Fatigue, etc       Yes       No       Kidney, Bladder issues       Yes       No       Thyroid, Diabetes       Yes       No         Ears, Nose, Throat issues       Yes       No       Muscles, Bones, Joints issues       Yes       No       Blood (Cholesterol, Anemia, etc)       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Nskin (Rash, Itching, etc)       Yes       No       Allergic, Immuno       Yes       No         Gastrointestinal       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Ambiyopia (Lazy Fye)       Yes       No       Macular Degeneration       Yes       No       Kidney Disease       Yes       No         Ambiyopia (Lazy Fye)       Yes       No       Retinal Detachment       Yes       No       Lupub       Yes       No         Cataract(s)       Yes       No       Cataractis       Yes       No       Lupub       Yes       No         Cataract(s)       Yes       No       Cataractis       Yes       No       Lupub       Yes       No         Gasucona Suppet       Yes       No       Cataractis       Yes       No       Hous Disease       Yes	Diabetic Retinopathy Yes	No	Macular Degeneration	Yes	No	Other	Yes	No		
Fever, Weight Loss, Fatigue, etc       Yes       No       Kidney, Bladder issues       Yes       No       Thyroid, Diabetes       Yes       No         Ears, Nose, Throat issues       Yes       No       Muscles, Bones, Joints issues       Yes       No       Blood (Cholesterol, Anemia, etc)       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Nskin (Rash, Itching, etc)       Yes       No       Allergic, Immuno       Yes       No         Gastrointestinal       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Ambiyopia (Lazy Fye)       Yes       No       Macular Degeneration       Yes       No       Kidney Disease       Yes       No         Ambiyopia (Lazy Fye)       Yes       No       Retinal Detachment       Yes       No       Lupub       Yes       No         Cataract(s)       Yes       No       Cataractis       Yes       No       Lupub       Yes       No         Cataract(s)       Yes       No       Cataractis       Yes       No       Lupub       Yes       No         Gasucona Suppet       Yes       No       Cataractis       Yes       No       Hous Disease       Yes										
Ears, Nose, Throat issues       Yes       No       Muscles, Bones, Joints issues       Yes       No         Cardiovascular (High BP etc.)       Yes       No       Skin (Rash, Itching, etc)       Yes       No       Allergic, Immuno       Yes       No         Respiratory (Asthma)       Yes       No       Neurological (Multiple Sclerosis)       Yes       No       Allergic, Immuno       Yes       No         Family History       Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       High Blood Pressure       Yes       No         Catarcat(s)       Yes       No       Macular Degeneration       Yes       No       Kidney Disease       Yes       No         Catarcat(s)       Yes       No       Athritis       Yes       No       Lupus       Yes       No         Catarcat(s)       Yes       No       Calcace Yes       No       Catarcat(Yes       No       Stroke Yes       No         Color Blindness       Yes       No       Calcace Yes       No       Calcace Yes       No       Othobases       Yes       No </td <td>_</td> <td></td> <td>Kidnov Pladdoricouco</td> <td></td> <td></td> <td>Thuroid Diabataa</td> <td></td> <td></td>	_		Kidnov Pladdoricouco			Thuroid Diabataa				
Cardiovascular (High BP etc.)       Yes       No       Skin (Rash, Itching, etc.)       Yes       No       Allergic, Immuno       Yes       No         Respiratory (Asthma)       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Family History       Ambiyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No         Ambiyopia (Lazy Eye)       Yes       No       Recipitatory (Asthma)       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Ambiyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Kidney Disease       Yes       No         Ambiyopia (Lazy Eye)       Yes       No       Retinal Detachment       Yes       No       Kidney Disease       Yes       No         Cataract(9)       Yes       No       Strabismus (Eye Tum)       Yes       No       Lupus Yes       No         Gaucoma Yes       No       Cataract (Yes       No       Disease       Yes       No       Others       Yes       No         Giaucoma Suspect       Yes       No       Heart Disease			57	<u> </u>	<b>—</b>		8	—		
Respiratory (Asthma)       Yes       No       Neurological (Multiple Sclerosis)       Yes       No       Pregnant       Yes       No         Family History       Ambiyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       Nursing       Yes       No         Family History       Ambiyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       High Blood Pressure       Yes       No         Ambiyopia (Lazy Eye)       Yes       No       Retinal Detachment       Yes       No       Kidney Disease       Yes       No         Cataract(s)       Yes       No       Strabismus (Eye Turn)       Yes       No       Lupus       Yes       No         Color Blindness       Yes       No       Cataract(s)       Yes       No       Cataract(s)       Yes       No         Glaucoma       Yes       No       Cataract(s)       Yes       No       Diabetes       Yes       No         Jobacco use / smoking frequency?       No       Heart Disease       Yes       No       Social History       Do you use recreational drugs?       Yes       No         Do you use recreational drugs?       Yes       No       Hobbies/Interests       Do you cu			· · · · ·	8	=	,	=	=		
Gastrointestinal       Yes       No       Anxiety or Depression       Yes       No       Nursing       Yes       No         Family History       Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       High Blood Pressure       Yes       No         Amblyopia (Lazy Eye)       Yes       No       Retinal Detachment       Yes       No       Kidney Disease       Yes       No         Cataract(s)       Yes       No       Stroke       Yes       No       Kidney Disease       Yes       No         Color Blindness       Yes       No       Cataract(s)       Yes       No       Cataract(s)       Yes       No         Color Blindness       Yes       No       Cataract(s)       Yes       No       Cataract(s)       Yes       No         Color Blindness       Yes       No       Cataract(s)       Yes       No       Cataract(s)       Yes       No         Glaucoma       System       No       Cataract Yes       No       Heart Disease       Yes       No         Jo you dink alcohol?       No       Occasional       1 Per Day       2-3 Per Day       4+ Per Day         Tobacco use / smoking frequency?       Do you use recreationa			· · · · · · · · · · · · · · · · · · ·			-				
Family History			÷ ( , , , , , , , , , , , , , , , , , ,			-		_		
Amblyopia (Lazy Eye)       Yes       No       Macular Degeneration       Yes       No       High Blood Pressure       Yes       No         Blindness       Yes       No       Retinal Detachment       Yes       No       Kidney Disease       Yes       No         Cataract(s)       Yes       No       Strabismus (Eye Turm)       Yes       No       Lupus       Yes       No         Color Blindness       Yes       No       Catract(s)       Yes       No       Lupus       Yes       No         Eye Turmors       Yes       No       Cancer       Yes       No       Thyroid Disease       Yes       No         Glaucoma       Yes       No       Diabetes       Yes       No       Others       Yes       No         Glaucoma Suspect       Yes       No       Heart Disease       Yes       No       Others       Yes       No         Glaucoma Suspect       Yes       No       Hobbies/Interests       Do       Out use recreational drugs?       Yes       No         Do you use recreational drugs?       Yes       No       Hobbies/Interests       Do you use recreational drugs?       Yes       No         Special Eyewear Needs       Computer (special prescriptions, specia		INO	Anxiety of Depression	res		Nursing	165			
Blindness       Yes       No       Retinal Detachment       Yes       No       Kidney Disease       Yes       No         Cataract(s)       Yes       No       Strabismus (Eye Turm)       Yes       No       Stroke       Yes       No         Color Blindness       Yes       No       Arthritis       Yes       No       Stroke       Yes       No         Color Blindness       Yes       No       Cancer       Yes       No       Thyroid Disease       Yes       No         Glaucoma       Yes       No       Cancer       Yes       No       Thyroid Disease       Yes       No         Glaucoma Suspect       Yes       No       Diabetes       Yes       No       Others       Yes       No         Social History       Do you drink alcohol?       No       Occasional       1 Per Day       2-3 Per Day       4+ Per Day         Tobacco use / smoking frequency?		_		_	_					
Cataract(s) Yes No Strabismus (Eye Turn) Yes No Lupus Yes No   Color Blindness Yes No Arthritis Yes No Stroke Yes No   Eye Turnors Yes No Cancer Yes No Thyroid Disease Yes No   Glaucoma Supect Yes No Diabetes Yes No Others Yes No   Glaucoma Supect Yes No Heart Disease Yes No Others Yes No   Social History No Occusaional 1 Per Day 2-3 Per Day 4+ Per Day Others Yes No   Do you drink alcohol? No Occusaional drugs? Yes No Hobbies/Interests Others Yes No   Do you use recreational drugs? Yes No Hobbies/Interests Others Yes No   Use nutritional supplements (vitamins etc.)? Yes No Special Eyewar Needs Sports/Hobbies (racquet sports, motorcycle)   Contact Lens History If not a contact lenses, pilots) Sports/Hobbies (racquet sports, motorcycle)   If not a contact lense wearer, are you interested in trying contact lenses at this time? Yes No   Have you ever tried to wear contact lenses? Yes No Since   Type and brand of contact lenses? Yes No Since   How many days/week? How many days/week? How many days/week?	Amblyopia (Lazy Eye)	No	Macular Degeneration	Yes	No	0	Yes	No		
Color Blindness Yes No   Color Blindness Yes No   Cancer Yes No   Cancer Yes No   Glaucoma Yes No   Cotor Blindness Yes No   Glaucoma Yes No   Cotor Blindness Yes No   Glaucoma Yes No   Cotor Blindness Yes No   Glaucoma Yes No   Glaucoma Yes No   Glaucoma Yes No   Cotor Blindness Yes No   Hobbies/Interests Do you drink alcohol? No   Do you use recreational drugs? Yes No   Hobbies/Interests Do you drink alcohol? No   Special Eyewear Needs Sports/Hobbies (racquet sports, motorcycle)   Contact Lens History If not a contact lens wearer, are you interested in trying contact lenses at this time?   Yes No Since <td>Blindness Yes</td> <td>No</td> <td>Retinal Detachment</td> <td>Yes</td> <td>No</td> <td>Kidney Disease</td> <td>Ξ</td> <td></td>	Blindness Yes	No	Retinal Detachment	Yes	No	Kidney Disease	Ξ			
Eye Tumors       Yes       No       Cancer       Yes       No         Glaucoma       Yes       No       Diabetes       Yes       No         Others       Yes       No       Diabetes       Yes       No         Glaucoma       Yes       No       Diabetes       Yes       No         Social History       Do you drink alcohol?       No       Occasional       1 Per Day       2-3 Per Day       4+ Per Day         Tobacco use / smoking frequency?	Cataract(s) Yes	No	Strabismus (Eye Turn)	Yes	No		Ξ	$\equiv$		
Glaucoma Yes   No Diabetes   Glaucoma Yes   No Heart Disease   Yes No     Social History   Do you drink alcohol?   No Occasional   1 Per Day   2-3 Per Day   4+ Per Day              Social History   Do you drink alcohol?   No   Occasional   1 Per Day   2-3 Per Day   4+ Per Day                  Social History   Do you use recreational drugs?   Yes   No <b>Social History</b> Do you ergage in regular exercise?    Yes   No   Special Eyewear Needs    Computer (special prescriptions, special anti-glare tints or coatings)   Sports/Hobbies (racquet sports, motorcycle)      Contact Lens History    If not a contact lens wearer, are you interested in trying contact lenses at this time?    Yes No   Have you ever tried to wea	Color Blindness Yes	No	Arthritis	Yes	No		<b>—</b>	=		
Glaucoma Suspect Yes   No   Heart Disease   Yes   No     Social History   Do you drink alcohol?   No        Ob you use recreational drugs?   Yes   No          Do you use recreational drugs?   Yes   No         Do you use recreational drugs?   Yes   No  Social History      Contact Lens History      If not a contact lenses?     Mo     Have you ever tried to wear contact lenses?      Po you currently wear contact lenses?      Yes     No     How many days/week?	Eye Tumors Yes	No	Cancer	Yes	No		=	—		
Social History   Do you drink alcohol?   No   Occasional   1   Per Day   Call   Attemport   Do you use recreational drugs?   Yes   No   Do you use recreational drugs?   Yes   No   Use nutritional supplements (vitamins etc.)?   Yes   No    Special Eyewear Needs     Computer (special prescriptions, special anti-glare tints or coatings)   Safety glasses (gardening, woodworking, welding)   Occupational (mechanics, plumbers, pilots)   Sportat Lens History   If not a contact lens wearer, are you interested in trying contact lenses at this time?   Yes   No    Reason for stopping?     Have you ever tried to wear contact lenses?   Yes   No    Reason for stopping?     How many days/week?	Glaucoma Yes	No				Others	Yes	No		
Do you drink alcohol? No Occasional 1 Per Day 2-3 Per Day 4+ Per Day   Tobacco use / smoking frequency?   Do you use recreational drugs? Yes No   Do you engage in regular exercise? Yes No   Use nutritional supplements (vitamins etc.)? Yes No     Special Eyewear Needs   Computer (special prescriptions, special anti-glare tints or coatings) Safety glasses (gardening, woodworking, welding)   Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)   Contact Lens History If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No Reason for stopping? Do you currently wear contact lenses? Yes No Since How many days/week? How many days/week?	Glaucoma Suspect Yes	No	Heart Disease	Yes	No					
Tobacco use / smoking frequency?         Do you use recreational drugs?       Yes         Do you engage in regular exercise?       Yes         Yes       No         Use nutritional supplements (vitamins etc.)?       Yes         Yes       No         Special Eyewear Needs       Special prescriptions, special anti-glare tints or coatings)       Safety glasses (gardening, woodworking, welding)         Occupational (mechanics, plumbers, pilots)       Sports/Hobbies (racquet sports, motorcycle)         Contact Lens History       If not a contact lens wearer, are you interested in trying contact lenses at this time?       Yes       No         Have you ever tried to wear contact lenses?       Yes       No       Reason for stopping?         Do you currently wear contact lenses?       Yes       No       Since         The or and of contact lenses       Hos       How many days/week?       Since	Social History									
Do you use recreational drugs? Yes No   Do you engage in regular exercise? Yes No     Use nutritional supplements (vitamins etc.)? Yes No     Special Eyewear Needs   Computer (special prescriptions, special anti-glare tints or coatings) Safety glasses (gardening, woodworking, welding)   Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)   Contact Lens History If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No Have you ever tried to wear contact lenses? Yes No Reason for stopping? Do you currently wear contact lenses? Yes No Since How many days/week?	Do you drink alcohol? No	ccasional	1 Per Day 2-3 Per Da	y 4	+ Per Day					
Do you engage in regular exercise? Yes   No   Use nutritional supplements (vitamins etc.)? Yes   No     Special Eyewear Needs   Computer (special prescriptions, special anti-glare tints or coatings)   Occupational (mechanics, plumbers, pilots)     Sports/Hobbies (racquet sports, motorcycle)        Contact Lens History   If not a contact lens wearer, are you interested in trying contact lenses at this time?   Yes   No   Have you ever tried to wear contact lenses?   Yes   No   Since   Type and brand of contact lenses	Tobacco use / smoking frequency?									
Do you engage in regular exercise? Yes   No   Use nutritional supplements (vitamins etc.)? Yes   No     Special Eyewear Needs   Computer (special prescriptions, special anti-glare tints or coatings)   Occupational (mechanics, plumbers, pilots)     Sports/Hobbies (racquet sports, motorcycle)        Contact Lens History   If not a contact lens wearer, are you interested in trying contact lenses at this time?   Yes   No   Have you ever tried to wear contact lenses?   Yes   No   Since   Type and brand of contact lenses	5 1 5									
Use nutritional supplements (vitamins etc.)? Yes No  Special Eyewear Needs Computer (special prescriptions, special anti-glare tints or coatings) Safety glasses (gardening, woodworking, welding) Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)  Contact Lens History If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No Have you ever tried to wear contact lenses? Yes No Do you currently wear contact lenses? Yes No Type and brand of contact lenses		•		bies/Inte	rests					
Special Eyewear Needs         Computer (special prescriptions, special anti-glare tints or coatings)       Safety glasses (gardening, woodworking, welding)         Occupational (mechanics, plumbers, pilots)       Sports/Hobbies (racquet sports, motorcycle)         Contact Lens History       If not a contact lens wearer, are you interested in trying contact lenses at this time?       Yes       No         Have you ever tried to wear contact lenses?       Yes       No       Reason for stopping?         Do you currently wear contact lenses?       Yes       No       Since         Type and brand of contact lenses       How many days/week?       How many days/week?										
□ Computer (special prescriptions, special anti-glare tints or coatings)       □ Safety glasses (gardening, woodworking, welding)         □ Occupational (mechanics, plumbers, pilots)       □ Sports/Hobbies (racquet sports, motorcycle)         Contact Lens History         If not a contact lens wearer, are you interested in trying contact lenses at this time?       □ Yes □ No         Have you ever tried to wear contact lenses?       □ Yes □ No       Reason for stopping?         □ Do you currently wear contact lenses?       □ Yes □ No       Since         Type and brand of contact lenses       □ Yes □ No       How many days/week?	Use nutritional supplements (vit	amins etc.)	? Yes No							
□ Computer (special prescriptions, special anti-glare tints or coatings)       □ Safety glasses (gardening, woodworking, welding)         □ Occupational (mechanics, plumbers, pilots)       □ Sports/Hobbies (racquet sports, motorcycle)         Contact Lens History         If not a contact lens wearer, are you interested in trying contact lenses at this time?       □ Yes □ No         Have you ever tried to wear contact lenses?       □ Yes □ No       Reason for stopping?         □ Do you currently wear contact lenses?       □ Yes □ No       Since         Type and brand of contact lenses       □ Yes □ No       How many days/week?	Special Evewear Needs									
Occupational (mechanics, plumbers, pilots)       Sports/Hobbies (racquet sports, motorcycle)         Contact Lens History       If not a contact lens wearer, are you interested in trying contact lenses at this time?       Yes       No         Have you ever tried to wear contact lenses?       Yes       No       Reason for stopping?         Do you currently wear contact lenses?       Yes       No       Since         Type and brand of contact lenses       How many days/week?       How many days/week?		special anti-	alare tints or coatings)	afety da	sses (nard	ening woodworking welding)				
Contact Lens History         If not a contact lens wearer, are you interested in trying contact lenses at this time?         Yes         No         Have you ever tried to wear contact lenses?         Yes         No         Do you currently wear contact lenses?         Yes         No         Since         How many days/week?										
If not a contact lens wearer, are you interested in trying contact lenses at this time? Ves No Have you ever tried to wear contact lenses? Yes No Do you currently wear contact lenses? Yes No Type and brand of contact lenses How many days/week?		ers, pilots)		ports/Ho	obles (laco	quel spons, molorcycle)				
If not a contact lens wearer, are you interested in trying contact lenses at this time? Ves No Have you ever tried to wear contact lenses? Yes No Do you currently wear contact lenses? Yes No Type and brand of contact lenses How many days/week?	Contact Lens History									
Do you currently wear contact lenses?       Yes       No       Since         Type and brand of contact lenses       How many days/week?										
Do you currently wear contact lenses?       Yes       No       Since         Type and brand of contact lenses       How many days/week?	Have you ever tried to wear contact lenses? Yes No Reason for stopping?									
Type and brand of contact lenses How many days/week?										
How many hours/day?										
	How many hou	rs/day?			rouays					

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Vison One. I understand that my primary insurance will be billed. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.