WELCOME TO VISION SOURCE!

PATIENT HISTORY FORM

EXAM DATE / /

LAST NAME | FIRST NAME | ❑M ❑F | BIRTH DATE / /

ADDRESS | CITY | STATE | ZIP CODE

CELL PHONE ( ) | OTHER PHONE ( ) | SOCIAL SEC#

EMPLOYER | OCCUPATION

REFERRED BY | EMAIL ADDRESS

INSURANCE INFORMATION

VISION INSURANCE PLAN | VISION ID # | MEDICARE #

MEDICAL INSURANCE PLAN | RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ CHILD (CHECK ONE)

INSURED ID# | INSURED DOB: / / | INSURED SS#

OCULAR AND MEDICAL HISTORY

WHAT IS THE REASON FOR TODAY'S VISIT?

AGE OF PRESENT GLASSES YRS | WOULD YOU LIKE NEW GLASSES? ❑ YES ❑ NO ❑ IF NECESSARY

LAST EYE EXAM / / | FROM DOCTOR | PREVIOUS PATIENT? ❑ YES ❑ NO

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	❑	❑	❑	GLAUCOMA	❑	❑	❑	DO YOU SEE DOUBLE?	❑	❑
HYPERTENSION	❑	❑	❑	CATARACTS	❑	❑	❑	FREQUENT HEADACHES?	❑	❑
THYROID DIS.	❑	❑	❑	RETINAL DISEASE	❑	❑	❑	BRIGHT LIGHTS BOTHER YOU?	❑	❑
HEART DISEASE	❑	❑	❑	EYE SURGERY	❑	❑	❑	DO YOU HAVE DRY EYES?	❑	❑
ASTHMA	❑	❑	❑	EYE INJURY	❑	❑	❑	ARE YOU PREGNANT?	❑	❑
CANCER	❑	❑	❑	OTHER				PRIMARY CARE DR.		

PLEASE EXPLAIN ANY POSITIVE FINDINGS:

PLEASE LIST YOUR PRESCRIPTION MEDICATIONS:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF YES, PLEASE EXPLAIN.

CONTACT LENS INFORMATION

DO YOU CURRENTLY WEAR CONTACT LENSES?	❑ YES ❑ NO	IF YES, WHAT TYPE?	
HAVE YOU EVER WORN CONTACT LENSES?	❑ YES ❑ NO	IF YES, WHAT TYPE?	
ARE YOU INTERESTED IN A CONTACT LENS PRESCRIPTION?	❑ YES ❑ NO	IF YES, WHAT TYPE?	

SPECIAL TASKS INFORMATION

DO YOU PARTICIPATE IN ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- ❑ NIGHT DRIVING
- ❑ FINE, DETAILED WORK (SEWING/ NEEDLEPOINT)
- ❑ EXTENDED READING
- ❑ COMPUTER USE -- HOW MANY HOURS/DAY?
- ❑ DANGEROUS WORK ENVIRONMENT (SAFETY Rx)

SMOKING HISTORY

- ❑ NEVER SMOKED
- ❑ FORMER SMOKER
- ❑ OCCASIONALLY
- ❑ CURRENT EVERYDAY SMOKER

RACE

- ❑ WHITE
- ❑ ASIAN
- ❑ AFRICAN AMERICAN
- ❑ HISPANIC
- ❑ PACIFIC ISLANDER
- ❑ AMERICAN INDIAN

FUNDUS EXAM

YOU ARE URGED TO HAVE A THOROUGH RETINAL EXAM IF YOU HAVE OR ARE EXPERIENCING ANY OF THE FOLLOWING:

- ■ DIABETES
- ■ HIGH BLOOD PRESSURE
- ■ SYMPTOMS OF FLASHES OF LIGHTS OR FLOATERS
- ■ FREQUENT OR SEVERE HEADACHES
- ■ PERSONAL OR FAMILY HISTORY OF GLAUCOMA
- ■ PERSONAL OR FAMILY HISTORY OF MACULAR DEGENERATION

❑ **YES, I WOULD LIKE TO HAVE MY EYES DILATED.**

PLEASE BE AWARE YOU WILL EXPERIENCE BLURRY VISION AND LIGHT SENSITIVITY FOR APPROXIMATELY 6 HOURS.

❑ **I WOULD PREFER RETINAL PHOTOS.**

OUR FUNDUS CAMERA WILL TAKE HIGH RESOLUTION PICTURES INSIDE YOUR EYES. YOU WILL BE ABLE TO REVIEW YOUR PHOTOS AND EYE HEALTH WITH OUR DOCTOR. THIS IS A NON-INVASIVE PROCEDURE THAT WILL MOST LIKELY NOT REQUIRE A DILATION, FOR A NOMINAL FEE OF $20.00.

❑ **NO, I ASSUME THE RESPONSIBILITY OF HAVING MY EYES EXAMINED WITHOUT A DILATION OR RETINAL PHOTOS.**

** IF PATIENT IS A MINOR, PARENT MUST SIGN. AUTHORIZED SIGNATURE DATE