

WELCOME TO OUR OFFICE



Vista Eye Care

Your vision is our focus

General Information

Today's Date ___/___/___

Last Name _____ First Name _____ MI _____ DOB: ___/___/___

Gender: M F SSN: ___-___-___ Spouse: _____ DOB: ___/___/___

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Emergency Contact: _____ Relation: _____ Phone: (____) _____

Employer/School: _____ Occupation/School Grade _____

Email Address: _____ Hobbies: _____

I have received, or was offered and declined, a notice of privacy practices:

Signature of responsible party _____

I understand that I am responsible for payment of services not covered by insurance:

Signature of responsible party _____

REASON FOR VISIT (check all that apply): Exam Glasses Contacts Eye infection/injury

Medical problem Other _____

Are you planning to get new glasses on this visit? Yes No If necessary

Do you have an interest in a "Test Drive" of the latest contact lens design? Yes No

PATIENT EYE HISTORY:

Date of last Eye Exam: ___/___/___ Eye Doctor's Name/Clinic _____

Do you wear glasses: All the time Occasionally Office Work Reading only Driving only Not at all

Do you currently wear contact lenses? Yes No If yes, list Brand/Prescription: _____

Do you currently use eye drops? Yes No If yes, please list: _____

Do You.....(check box if your answer is yes):

Work at a computer? (____hrs/day) Have computer or reading glasses?

Spend time outdoors? (____hrs/week) Have prescription sunglasses?

Do you or have you ever had (check box if answer is yes):

Macular Degeneration Eye injuries If yes, which eye? _____ when? _____

Cataracts Eye surgeries If yes, type? _____ which eye? _____ when? _____

Glaucoma Other Eye Condition If yes, please list: _____

Do you currently or have you recently experienced any of the following? (check box if yes):

Blurred vision Burning eyes Floaters Headaches

Itching eyes Watery eyes Flashes of light Double vision

Red eyes Sandy/gritty feeling Loss of vision Eye strain

Dry eyes Eye pain Poor night vision Light sensitivity

PATIENT MEDICAL HISTORY

PLEASE CHECK ANY OF BOXES THAT APPLY TO YOU AND LIST ANY MEDICATIONS TAKEN FOR EACH CONDITION THAT YOU CHECK. *PLEASE CHECK "NONE" IF YOU DO NOT HAVE THE CONDITIONS.*

Allergies (please list): <input type="checkbox"/> None <input type="checkbox"/> Drug Allergies: <input type="checkbox"/> Environmental Allergies: Medications: _____	Genitourinary: <input type="checkbox"/> None <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> STD – Herpes/Chlamydia <input type="checkbox"/> Other: Medications: _____	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Arthritis(<input type="checkbox"/> osteo <input type="checkbox"/> rheumatoid) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Other: Medications: _____
Cardiovascular <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease/Heart Attack <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Other: Medications: _____	Immunologic: <input type="checkbox"/> None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Herpes Zoster(Shingles)/Simplex <input type="checkbox"/> Lupus <input type="checkbox"/> Sjogren's <input type="checkbox"/> Other: Medications: _____	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other: Medications: _____
Constitutional <input type="checkbox"/> None <input type="checkbox"/> Dizziness/fainting <input type="checkbox"/> Recent weight gain/loss <input type="checkbox"/> Excess thirst/urination <input type="checkbox"/> Other: Medications: _____	Integumentary(skin) <input type="checkbox"/> None <input type="checkbox"/> Acne Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Other: Medications: _____	Neurological: <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Bell's Palsy <input type="checkbox"/> Parkinson's <input type="checkbox"/> Other: Medications: _____
Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Diabetes (<input type="checkbox"/> type I <input type="checkbox"/> type II) <input type="checkbox"/> Thyroid Problem (<input type="checkbox"/> hypo <input type="checkbox"/> hyper) <input type="checkbox"/> Other: Medications: _____	Head/ENT: <input type="checkbox"/> None <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Hearing Loss (<input type="checkbox"/> Full <input type="checkbox"/> Impaired) <input type="checkbox"/> Other: Medications: _____	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> Alzheimers/Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Other: Medications: _____
Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> Hepatitis/Liver disease <input type="checkbox"/> Colitis <input type="checkbox"/> Other: Medications: _____	Hematologic/Lymphatic <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: Medications: _____	Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No # packs per day: _____ Are you currently pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any other medical conditions and medications and/or drugs that you are taking (including herbal) that are not listed above: _____

Date of Last Medical/Physical Exam: ___/___/____ Primary Care Physician: _____

FAMILY HISTORY: Has anyone in your immediate family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with any of the following conditions,

If yes, please list family member:

Glaucoma: _____ Retinal Detachment: _____ Diabetes: _____
 Macular Degeneration: _____ High Blood pressure: _____ Heart Disease: _____

Who may we thank for referring you to our office?

Name of friend, relative or doctor: _____

If not referred, how did you choose our office for your needs?

Insurance List Newspaper Advertisement
 Saw building/Sign Web Site: _____
 Yellow Pages Other: _____

Reviewed by: _____ Date _____