Welcome To Our Office!

Vision Associates
Family Eye Care

Patient Information:

Last name _____ First name _____ MI _____

Mailing Address _____ City _____ State _____ Zip _____

Birthdate _____ Sex: ☐ M ☐ F SSN _____ Marital Status _____

Cell Phone _____ Texting OK (Non-Marketing)? ☐ Yes ☐ No Home Phone _____

Work Phone _____ Email Address _____

Occupation _____ Employer _____

Communication Preference: ☐ Text to Cell Phone ☐ Call to Cell Phone ☐ Email ☐ Home Phone ☐ Work Phone ☐ Postal Mail

REVIEW OF SYSTEMS: Do you have health problems with any of these systems? Please check all that apply.

☐ Allergy	☐ Gastrointestinal	☐ Immunologic	☐ Neurological
☐ Cardiovascular (Heart)	☐ Ear, Nose, Mouth, Throat	☐ Skin	☐ Psychiatric
☐ Endocrine (Diabetes, Thyroid)	☐ Blood/Lymphatic	☐ Musculoskeletal	☐ Respiratory

Please explain: _____

_____

MEDICAL HISTORY: Name of Primary Physician _____

Current Medications _____

Medication Allergies _____

Current Medical Conditions _____

_____

Any major surgeries? Please explain _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs

Race*: ☐ White ☐ African American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other (*Response Optional)

Ethnicity*: ☐ Hispanic ☐ Non-Hispanic ☐ Pacific Islander Preferred Language*: _____

FAMILY MEDICAL HISTORY: Has anyone in your family had the following conditions? If so, please indicate who.

☐ Diabetes	_____	☐ Rheumatoid Arthritis	_____	☐ Keratoconus	_____
☐ Hypertension	_____	☐ Glaucoma	_____	☐ Colorblindness	_____
☐ High Cholesterol	_____	☐ Macular Degeneration	_____	☐ Lazy/Turned Eye	_____
☐ Heart Disease	_____	Other Condition:	_____		

OCULAR HISTORY: Date of Last Eye Exam _____ By Dr. _____

Have you had any eye surgeries? ☐ Yes ☐ No Type and Year: _____

Have you had any eye injuries? ☐ Yes ☐ No Type and Year: _____

Do you have:					
☐ Glaucoma	☐ Keratoconus	☐ Near Vision Blur	☐ Double Vision	☐ Watery Eyes
☐ Cataracts	☐ Amblyopia	☐ Distance Blur	☐ Floaters	☐ Itchy Eyes
☐ Macular Degeneration	☐ Strabismus	☐ Middle Vision Blur	☐ Flashes of Light	☐ Dry Eyes
☐ Colorblindness	☐ Double Vision	☐ Headaches	☐ Halos/Glare	☐ Red Eyes

Do you currently wear glasses? ☐ Yes ☐ No Do you currently wear contact lenses? ☐ Yes ☐ No What kind? _____

What is the reason for today's visit? _____

Are you having any eye problems? _____

Signature _____ Date _____