Welcome to

Vision Source™ @ Jordan Landing

Name_____ Date_____/_____/_____

Street Address_____ City_____ State ____ Zip _____

Home Phone _____Work Phone_____ Cell Phone_____

Email Address_____

Gender: M F Birth date_____/_____/_____ Social Security #_____

Patient Employer (or school) _____ Patient Occupation (or grade)_____

Person responsible for payment on account_____ Relationship to patient_____

If you are enrolled in a vision plan (VSP, Superior Vision, EyeMed), please list the vision plan as Primary, and the medical plan as Secondary

Primary Insurance Company_____ Insured's Name _____

Insured's Social Security # (or ID #)_____Insured's Birthdate_____/_____/_____

Secondary Insurance Company _____ Insured's Name_____

Insured's Social Security # (or ID #)_____Insured's Birthdate_____/_____/_____

Health History Questionnaire

PERSONAL OCULAR HISTORY:

Injuries, surgeries, and/or infections_____

PERSONAL MEDICAL HISTORY:

Injuries, surgeries, and/or hospitalizations_____

_____

SYSTEMIC FAMILY HISTORY:

Arthritis	NO	YES	Relationship to you_____
Cancer	NO	YES	Relationship to you_____
Diabetes	NO	YES	Relationship to you_____
Heart Disease	NO	YES	Relationship to you_____
High Blood Pressure	NO	YES	Relationship to you_____
High Cholesterol	NO	YES	Relationship to you_____
Thyroid Disease	NO	YES	Relationship to you_____
Other_____			Relationship to you_____

OCULAR FAMILY HISTORY:

Blindness	NO	YES	Relationship to you_____
Cataracts	NO	YES	Relationship to you_____
Glaucoma	NO	YES	Relationship to you_____
Lazy Eye	NO	YES	Relationship to you_____
Macular Degeneration	NO	YES	Relationship to you_____
Retinal Disease	NO	YES	Relationship to you_____
Other_____			Relationship to you_____

(please complete reverse side as well)

OCULAR MEDICATIONS: (including over-the-counter)_____

SYSTEMIC MEDICATIONS: (including over-the-counter)_____

_____

SOCIAL HISTORY:

Use of alcohol, tobacco, or illegal drugs? NO YES Type/Quantity/Frequency_____

CURRENT GLASSES STATUS:

Do you currently wear glasses? NO Distance Only Reading Only Computer Full Time

CURRENT CONTACT LENS STATUS:

Do you currently wear contact lenses? NO YES Brand_____ Power: R_____ L_____

Personal Review of Systems

ALLERGIES OR DRUG HYPERSENSITIVITIES (including type of reaction)_____

_____

CARDIOVASCULAR

None Heart Disease High Blood Pressure High Cholesterol Other_____

CONSTITUTIONAL

None Anemia Excessive Hunger/Thirst/Urination Fever Other_____

ENDOCRINE

None Diabetes Gout Hyperthyroid Hypothyroid Other_____

GASTROINTESTINAL

None Constipation Diarrhea Stomach Ulcer Other_____

GENITOURINARY

None Bladder/Kidney Infection Menopause STD Other_____

INTEGUMENTARY

None Rosacea Skin Cancer Stevens-Johnson Syndrome Other_____

MUSCULOSKELETAL

None Arthritis Myasthenia Gravis Osteoporosis Other_____

NEUROLOGICAL

None Headaches Multiple Sclerosis Seizures Other_____

PSYCHIATRIC

None Alzheimer's Anxiety Depression Other_____

RESPIRATORY

None Asthma Chronic Bronchitis Emphysema Other_____

Additional Information

Reason for your visit today (ie: new glasses/contact lenses, LASIK evaluation, dry eye – gritty/sandy/burning/tired feeling – red eye, flashes/floaters, eye pain or discharge, etc)_____

_____

Please list any visual needs relating to your occupation, recreation, or hobbies_____

_____

How did you find out about our office?_____