

Welcome to

VISION SOURCE™ @ Jordan Landing

Name _____ Date ____/____/____

Gender: M F Other Birthdate ____/____/____ Social Security# _____

Phone: Home _____ Work _____ Cell _____

Address _____ City _____ State ____ Zip _____

Email Address _____

Employer (or school) _____ 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 ____/____/____

Insured's Address (if different) _____ City _____ State ____ Zip _____

Secondary Insurance Company _____ Insured's Name _____

Insured's Social Security # (or ID #) _____ Insured's Birthdate ____/____/____

Insured's Address (if different) _____ City _____ State ____ Zip _____

Health History Questionnaire

PERSONAL OCULAR HISTORY:

Injuries, surgeries, and/or infections _____

PERSONAL MEDICAL HISTORY:

Injuries, surgeries, and/or hospitalizations _____

SYSTEMIC FAMILY HISTORY:

None Arthritis Cancer Diabetes Hypertension High Cholesterol Thyroid Disease

Other _____

OCULAR FAMILY HISTORY:

None Cataract Glaucoma Macular Degeneration Strabismus (Crossed) or Amblyopia (Lazy Eye)

Other _____

(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 narcotics? NO YES Type/Quantity/Frequency _____

CURRENT EYEWEAR STATUS:

Do you currently wear glasses? NO Distance Only Reading Only Computer Progressive Bifocal

CURRENT CONTACT LENS STATUS:

Do you currently wear contact lenses? NO YES Brand _____

Power: R _____ L _____ (include astigmatism, if applicable)

Personal Review of Systems

ALLERGIES OR DRUG HYPERSENSITIVITIES (including type of reaction) _____

PLEASE LIST ANY CURRENT MEDICAL DIAGNOSES IN THE FOLLOWING CATEGORIES (for example: heart disease, diabetes, menopause, skin problems, arthritis, headaches, multiple sclerosis, anxiety/depression, asthma, etc), or mark "none"

Cardiovascular _____ None Constitutional _____ None

Endocrine _____ None Gastrointestinal _____ None

Genitourinary _____ None Integumentary _____ None

Musculoskeletal _____ None Neurological _____ None

Psychiatric _____ None Respiratory _____ None

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? _____