Welcome to

Vision Source™ at Jordan Landing

Name: _____ Date: ____/_____/_____

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

Preferred Language: _____ Ethnicity/Race: _____ Call or Text preferred: _____

Phone: Home: _____ Work: _____ Cell: _____

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

Apt/Unit: _____ Email Address: _____

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

Insurance policy holder or person responsible for payment: _____ Relationship to patient: _____

Medical Insurance Company: _____ Insured's Name: _____

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

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

Vision 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:

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):

_____

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

_____

SOCIAL HISTORY:

Use of alcohol? NO YES Type/Quantity/Frequency_____
Use of tobacco? NO YES Type/Quantity/Frequency_____
Use of narcotics? NO YES Type/Quantity/Frequency_____
Use of cannabis? 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 _____

_____

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?

_____

_____