Vision Source Prescott

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced / Widowed

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

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

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

Preferred Language _____ Race: _____ Ethnicity: _____

Communication Preference: ___Telephone ___Postal ___ E-mail Referred by: _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

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

Do you wear glasses? Yes No All the time Sometimes Work Only Reading only Driving only

How old are your present glasses? _____ Do you wear prescription Sun Wear: Yes No

Do you wear contact lenses? Yes No Type:_____ Solution Used: _____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Have you ever had an eye injury? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Are you currently using eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneration: Yes No When were you diagnosed?_____

Do your eyes ever feel dry or uncomfortable? Yes No

Are you bothered by changes in your vision throughout the day? Yes No

Are you ever bothered by red eyes? Yes No

Do you ever use or feel the need to use rewetting eye drops? Yes No

What are your visual symptoms: Please circle any that apply and indicate Right, Left or Both:

Blurred Vision/Distance	R L B	Itchy Eyes	R L B	Headaches	R L B
Blurred Vision/Near	R L B	Watery Eyes	R L B	Light Sensitive	R L B
Double Vision	R L B	Crossed Eyes	R L B	Poor Color Vision	R L B
Eye Strain	R L B	Wandering eye	R L B	Poor Night Vision	R L B
Eye Pain/Soreness	R L B	Mucus Discharge	R L B	Droopy Lid	R L B
Loss of Vision	R L B	Floaters or Spots	R L B	Flashes	R L B

Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ **None** ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Elevated Cholesterol ___ Other:	**Endocrine:** ___ **None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** ___**None** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Sleep Apnea ___ Other:
Constitutional: __ **None** ___ Fever/Weight gain/loss ___ Weakness/Fatigue ___ Increase of thirst/urination ___ Other:	**Ocular** __ **None** ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** __ **None** ___ ADHD/ADD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ **None** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Migraine ___ Other:	**Musculoskeletal:** __ **None** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** __ **None** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ **None** ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** __ **None** ___ Crohn's ___ Colitis ___ Acid Reflux ___ Other:	**Ear/Nose/Throat:** __ **None** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ **None** ___ Eczema ___ Rosacea ___ Psoriasis ___ Skin Cancer ___ Other	**Allergies** (please list) __ **None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** **Amount:** **Quit:** ____

Surgeries (type & dates): _____

_____

Please list any medications and/or drugs that you are taking (including herbal) : See Attached List: _____

1 _____	**For** _____	**6** _____	**For** _____
2 _____	**For** _____	**7** _____	**For** _____
3 _____	**For** _____	**8** _____	**For** _____
4 _____	**For** _____	**9** _____	**For** _____
5 _____	**For** _____	**10** _____	**For** _____

FAMILY HISTORY: Has anyone in your immediate family (parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION					
High Blood Pressure:	Yes No	_____	Cataracts:	Yes No	_____
Diabetes:	Yes No	_____	Glaucoma:	Yes No	_____
Cancer:	Yes No	_____	Macular Degeneration:	Yes No	_____
Thyroid Disease:	Yes No	_____	Retinal Detachment:	Yes No	_____

Reviewed by:

Dr _____ Date _____

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