New Patient Information

Welcome to our office! Please complete this questionnaire in full to help us better serve you!

Name: Mr. Mrs. Ms. Dr. _____ Today's Date: _____

Address: _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____ _____

Which number is your primary number? Home ☐ Work ☐ Cell ☐ Email address: _____

Communication Opt-In: How would you like to be notified about...

	Home	Work	Cell	Email	Text	Mail	None
Appointments							
Recalls							
Orders							
Education							

DOB: _____ SSN: _____

Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Other ☐

Vision Insurance: _____ Policy # _____

Medical Insurance: _____ Policy # _____

Please list all current medications: _____

_____

_____

_____

_____

Your Pharmacy: _____

Please list any Medication Allergies: _____

_____

_____

Other Allergies: _____

_____

_____

_____

Do you: Drink ☐ Smoke ☐ Use smokeless tobacco ☐ Amount: _____

Please go to the next page!

Name_____

Review of Systems: Please circle all that apply to you, or circle "NONE" if none apply.

Neurological

NONE

Multiple Sclerosis

Epilepsy

Cerebral Palsy

Tumor

Stroke/CVA

Migraine

Autism Spectrum Disorder

Other_____

Cardiovascular

NONE

Hypertension

Stroke/CVA

Heart Disease

Vascular Disease

Congestive Heart Failure

Other_____

Psychiatric

NONE

Depression

Attention Deficit

Anxiety Disorder

Bipolar Disorder

Other_____

Musculoskeletal

NONE

Arthritis

Osteoarthritis

Fibromyalgia

Muscular Dystrophy

Ankylosing Spondylitis

Osteoporosis

Gout

Other_____

Gastrointestinal

NONE

Crohn's

Colitis

Ulcer

Acid Reflux

Celiac Disease

Other_____

Endocrine

NONE

Diabetes Type I

Diabetes Type II

Thyroid dysfunction

Hormonal dysfunction

Other_____

Respiratory

NONE

Cigarette Smoker

Asthma

Bronchitis

Emphysema

Chronic Obstruction

Sleep Apnea

Other_____

Integumentary

NONE

Eczema

Rosacea

Psoriasis

Cold Sores

Shingles

Other_____

Hemotologic/Lymphatic

NONE

Anemia

Large-Volume blood loss

Ulcer

High Cholesterol

Other_____

Genitourinary

NONE

Kidney Disease

Prostate disease/cancer

STD_____

Benign Prostate Hypertrophy

Pregnant

Nursing

Other_____

ENT

NONE

Hearing Loss

Sinusitis

Dry Mouth

Laryngitis

Other_____

Allergic/Immune

Environmental Allergies

Rheumatoid Arthritis

Lupus

Sjogren's Syndrome

Other_____

Constitutional

Developmental Disabilities

Cancer

Fatigue Syndrome

Other_____

Name _____ Family History

Condition	Father	Mother	Brother	Sister	Son	Daughter
Cancer	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Diabetes (Type 1)	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Diabetes (Type 2)	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Hypertension	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Hyperthyroidism	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Cataracts	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Glaucoma	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N
Macular Degerneration	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N	N/R U Y N

N/R=Not relevant U=Unknown Y=Yes N=No

Have you ever had any of the following Eye Problems? If so, please describe in as much detail as possible.

Glaucoma Suspect:
_____

Glaucoma:_____

Cataract:_____

Age-Related Macular Degeneration:
_____

Surgery:_____

Patching:_____

Inflammatory Disorder:
_____

Strabismus:_____

Amblyopia:_____

Retinal Degeneration:
_____

Retinal Hole:
_____

Retinal Detachment:
_____

Keratoconus:_____

Injury:
_____

Dry Eye:
_____

Nystagmus:
_____

Other:
_____
_____
_____
_____
_____

Encounter Questionnaire

Welcome to our office please fill out this questionnaire in full to help us better serve you!

Name: _____ Date: _____

**Has any of your personal information changed since your last visit? (Phone number, address, insurance, etc.) **

☐ YES—**Please see the front desk to update your information!!!**

☐ NO

Reason for Today's Visit _____

_____

Routine Eye Exam ☐

Contact Lens Evaluation ☐

Glaucoma/IOP Check ☐

Post Op Cataract Exam ☐

Post Op Lasik Exam ☐

Eye Problem ☐

Is Today's Visit Related to: Employment ☐ Auto Accident ☐ Other Accident ☐ ?

Have you ever been diagnosed with any of the following conditions? (Circle all that apply.)

Cataract

Age-Related Macular Degeneration

Glaucoma

Diabetes

Diabetic Retinopathy

Dry Eye

Eye Infection, Inflammation, or allergy

Floaters and/or Flashes of Light

Iritis or Uveitis

Retina defects or degeneration

Other_____

Are you having any of the following eye concerns TODAY? (Circle all that apply.)

Redness

Burning

Itching

Tearing

Discharge

Other_____

Are you having any of the following vision concerns TODAY? (Circle all that apply.)

Blurred Vision

Eye Strain

Eye Pain

Severe Sensitivity to Light

Headache

Poor Night Vision

Bothersome Night Glare

Double Vision

Total Loss of Vision

Other_____

Name_____

What corrective lenses are you mainly using for far/distant vision activities? None ☐ Glasses ☐ Contact Lenses ☐

Describe the quality of your far/distant vision activities? Acceptable ☐ May Need Improvement ☐ Blurred

What corrective lenses are you mainly using for near/reading vision activities? None ☐ Glasses ☐ Contact Lenses ☐

Describe the quality of your near/reading vision activities? Acceptable ☐ May Need Improvement ☐ Blurred ☐

What corrective lenses are you mainly using for computer vision activities? None ☐ Glasses ☐ Contact Lenses ☐

Describe the quality of your computer vision activities? Acceptable ☐ May Need Improvement ☐ Blurred

Please tell us any about additional concerns with your current corrective lenses. _____

_____

_____

_____

_____

_____

Contact Lens History

What brand of contacts are you currently wearing?_____

How old are the lenses you are currently wearing?_____

Do you sleep in your contacts? _____

Average Daily Wearing Time?_____

Today's Wearing Time?_____

Average Replacement Period?_____

Continuous Wear Period?_____

Solutions Used? _____

Drops Used?_____

20/20 Eye Care

Acknowledge of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received 20/20 Eye Care Notice of Privacy Practices:

Patient Name: _____ Patient Date of Birth: _____

Any physician, staff, employee o representative of 20/20 Eye Care has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)

20/20 Eye Care calls and sends recall notices for appointments via mail by post card or on occasion we may send an email or text message if we are unable to reach you by phone.

Please check if this is agreeable with you:

____ Post Card
____ Text to my cell phone
____ Email

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to 20/20 Eye Care or complete a new form at any time. This authorization will remain in effect until I change or Revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals.

Patient or Guardian's Signature _____ **Date** _____