PATIENT INFORMATION PLEASE PRINT CLEARLY

Last Name:_____ First:_____ M / F DOB:_____/_____/____

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

Phone: HOME ( )_____ CELL ( )_____ Email_____

Health Insurance:_____ ID#_____ Vision Insurance_____

Insurance Subscriber's Name:_____ DOB:_____/_____/_____ VSP Vision ID# _____

PCP:_____ Phone #( )_____ Practice Name_____ State:_____

Your Occupation:_____

I have reviewed the Notice of Privacy Practices: SIGNATURE_____Date:_____/_____/_____

PATIENT / FAMILY HISTORY

1. What is the reason for todays visit?_____

2. Age of present glasses:_____ Last Exam Date:_____ From DR._____

DO YOU OR ANY BLOOD RELATIVES HAVE ANY OF THE FOLLOWING:

High Cholesterol	Y / N	Who	_____	Cataracts	Y / N	Who	_____
High Blood Pressure	Y / N	Who	_____	Glaucoma	Y / N	Who	_____
Heart Disease	Y / N	Who	_____	Thyroid	Y / N	Who	_____
Diabetes	Y / N	Who	_____	Retinal Issues	Y / N	Who	_____

3. ARE YOU TAKING ANY MEDICATIONS? Y / N IF YES, PLEASE LIST

_____

4. DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? Y / N IF YES, PLEASE LIST

_____

5. ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST

_____

6. HAVE YOUR EYES EVER BEEN DILATED?

7. HAVE YOU EVER HAD AN EYE INFECTION, DISEASE AND / OR SURGERY? IF YES, PLEASE LIST

_____

8. DO YOU EVER SEE DOUBLE?	Y / N	If YES, when	_____
9. DO YOU HAVE FREQUENT HEADACHES?	Y / N	If YES, when	_____
10. DOES BRIGHT LIGHT / NIGHT VISION BOTHER YOU?	Y / N	If YES, when	_____
11. DO YOU WORK WITH A COMPUTER / VIDEO GAMES?	Y / N	If YES, when	_____
12. WHAT SPORTS / HOBBIES DO YOU ENJOY?		_____	_____

CONTACT LENS HISTORY

13. DO YOU WEAR CONTACT LENSES?	Y / N	IF YES, WHAT BRAND?_____
13a. DO YOU WANT TO BE FITTED FOR CONTACTS?	Y / N	
14. HAVE YOU EVER WORN CONTACT LENSES?	Y / N	IF YES, HOW LONG AGO? _____

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