Welcome to Visual Eyes - *Your Lifetime Eyecare Center*

Today's Date: _____ **Date of Last Eye Exam:** _____

Contact Information

Name: _____

Street: _____

City_____ State _____

Zip code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address:

_____

Personal Information

Employer:

_____

SS Number: _____- _____- _____

DOB: _____ Age _____

Sex: _____Male _____Female

Spouse/Parent Name:

_____

Spouse /Parent Cell Phone:

_____

Personal & Family Medical History
Circle all that apply:

Allergies	Yes	No
Asthma	Yes	No
Arthritis	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Eye Diseases	Yes	No
Heart Disease	Yes	No
Eye Injury	Yes	No
High Blood Pressure	Yes	No

Current Medications
(Rx & Over -the-Counter)

Antihistamines	Yes	No	_____
Diuretics (Water Pill)	Yes	No	_____
Blood Pressure Pills	Yes	No	_____
Oral Contraceptives	Yes	No	_____
Sleeping Pills	Yes	No	_____
Eye Drops	Yes	No	_____

Vitamins or Other Supplements _____

Are you currently under the care of a physician? Yes No
Name of physician: _____

How did you hear about us?

- ☐ Friend or relative
- ☐ Another healthcare Practitioner
- ☐ Yellow Pages
- ☐ Newspaper Advertisement
- ☐ Direct Mailer
- ☐ Another patient
- ☐ Participating eye care plan

Please provide us with a name of any of the referral sources checked above so we may thank them properly:

_____

_____

_____

Diagnostic Issues/ Lifestyle Questions

Please list any complaints or problems you have wearing glasses or contact:

_____

_____

_____

Do you have more that 1pair of current prescription glasses? **No** **Yes**

Do you work on a computer for long periods of time? **No** **Yes**

If you wear glasses, would you benefit form thinner, lighter lenses? **No** **Yes**

Do you spend a lot of time outdoors? **No** **Yes**

If you wear bifocals, are you bothered by restricted windows, lines or head tilting? **No** **Yes**

If you wear contact lenses, are you satisfied with vision and comfort? **No** **Yes**

Are you interested in a "trial" of the latest in contact lens design? **No** **Yes**

Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? **No** **Yes**

Do You Experience...

- Any discomfort with your eyes? **No** **Yes**
- Problems with glare or reflection? **No** **Yes**
- Sensitivity to light? **No** **Yes**
- Headaches? **No** **Yes**
- Floaters or flashes of light? **No** **Yes**

Dilation....

To dilate your eyes, the doctor will use drops to cause your pupils to enlarge. With the pupils dilated, the doctor has a better opportunity to examine the inside of your eyes. If you are a new patient to the practice or you have a family history of eye health or general heath problems, the doctor will suggest having your pupils dilated today. The drops are fast acting and usually take effect in 20-30minuites. The total effect on vision lasts 3-5hours with near vision being affected most. It will be safe to drive home after having your pupils dilated.

_____**I wish** ____**I do not** with to be dilated today. _____ **(initial)**

Thank you....

The information you have provided will help us serve your health care needs more effectively. If you have any questions at any time, please ask, we are always happy to help.

_____ _____

Patient Signature **Date**

Patient Privacy Notice-Acknowledgement of Receipt

At your initial visit a copy of the Visual Eyes privacy practices will be presented to you. After you have read our privacy notice please sign and date below to acknowledge you received the information.

_____ _____

Patient Signature **Date**