VISION SOURCE™

Patient Information Form

First Name _____ Last Name _____ Middle Initial ____ Date of Birth _____ Age _____

Street Address/ PO Box _____ City _____ State _____ Zip _____ SSN _____

Sex M / F Marital Status _____ Email Address _____ Home Phone # _____ Cell Phone # _____

First Visit? Y / N Reason for Today's Visit _____ Last Eye Exam Date _____ Referred By _____

Other Contact Information

Person Responsible for charges (if not patient) _____ Relationship to Patient _____ Home Phone # _____ Work phone # _____

Eye-Health (Check all that apply to the patient)

- ☐ Amblyopia
- ☐ Blurred Vision – Far
- ☐ Blurred vision – Near
- ☐ Burning Eyes
- ☐ Cataracts
- ☐ Double / Distorted Vision
- ☐ Drooping Eyelid
- ☐ Dry Eyes
- ☐ Eye Surgeries
- ☐ Eye Turn
- ☐ Floaters / Spots
- ☐ Fluctuating Vision
- ☐ Foreign Body Sensations
- ☐ Glaucoma
- ☐ Glare / Light Sensitivity
- ☐ Headaches
- ☐ Itchy Feelings
- ☐ Infection of Eye / Lid
- ☐ Loss of Vision – Central
- ☐ Loss of Vision – Side
- ☐ Mucus / Discharge
- ☐ Redness
- ☐ Retinal Detachment
- ☐ Tearing / Watery Eyes

General Health (Check all that apply to the patient)

- ☐ Allergies / Hay Fever
- ☐ Asthma / Respiratory
- ☐ Blood Disorders / Anemia
- ☐ Cancer
- ☐ Cardiovascular / High B.P.
- ☐ Chronic Bronchitis
- ☐ Cholesterol
- ☐ A.D. D. / A.D.H.D
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Emphysema
- ☐ Gastrointestinal Problems
- ☐ Hearth Attack / Stroke
- ☐ Headaches / Migraines
- ☐ Gout
- ☐ Other: _____
- ☐ Kidney Disease
- ☐ Psychiatric / Depression
- ☐ Rheumatoid Arthritis
- ☐ Thyroid / Endocrine Disease
- ☐ Skin Disorders / Lupus
- ☐ Weight Loss / Gain
- ☐ Hepatitis

Family History (Check all that apply)

- ☐ Amblyopia (Lazy Eye)
- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataract(s)
- ☐ Color Blindness
- ☐ Diabetes
- ☐ Eye Turn
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Stroke / Heart Attack
- ☐ Thyroid Disease

Social History (Check all that apply to the patient)

- ☐ Drink
- ☐ Smoke
- ☐ S.T.D.'s
- ☐ Recreational Drugs

Family Physician

_____	_____	_____
Physician's Name	Physician's Phone #	Last Medical Exam Date

Medications (List condition if you do not know the name of the medication)

	Medication	Condition		Medication	Condition
1.	_____	_____	2.	_____	_____
3.	_____	_____	4.	_____	_____
5.	_____	_____	6.	_____	_____
7.	_____	_____	8.	_____	_____

Enter the name of all medications (or Substances) to which the patient is allergic

1. _____ 2. _____

3. _____ 4. _____

Please Answer the Following Questions

Are you pregnant or nursing? Y / N Do you have trouble driving at night? Y / N
Do you wear glasses? Y/ N Contacts? Y / N If yes, Type: _____
Do you experience blur, headaches or eyestrain with computer use? Y / N
Are you interested in laser (refractive) surgery to correct your vision? Y / N

Vision Insurance Information

Insurance Company _____ Primary Insured's Sex M / F
Patient's Relationship to Insured → Self Spouse Child Other:_____
Insured ID # _____ Group # _____ Insured's Date of Birth _____
Insured's Name _____ Insured's Phone # _____

Medical Insurance Information

Insurance Company _____ Primary Insured's Sex M / F
Patient's Relationship to Insured → Self Spouse Child Other:_____
Insured ID # _____ Group # _____ Insured's Date of Birth _____
Insured's Name _____ Insured's Phone # _____

Please enter any comments or addition information we should know

_____

_____