
Patient Information

Patient Name _____ Date _____

Address _____ City _____

State _____ Zip _____

Parent or Guardian _____ Same address as patient? Yes No
(if patient is a minor or assigned a guardian)

Address of Guardian _____
(if different than patient)

Phone numbers: (please provide numbers which we may call to contact you)

Home _____ Work _____ Cell _____

Email address _____

Patient's date of birth ____/____/____ Patient occupation _____

Patient's employer/occupation _____ Student FT PT

Insurance Information

Do you have vision insurance? No Yes _____

Do you have medical insurance? No Yes _____ Copay \$ _____

Policy holder name _____ Date of birth ____/____/____

Policy holder ID number or SS# _____

Glasses/Contact Lenses

Do you wear glasses Yes No If yes, how old are your glasses _____

What type of glasses do you wear Reading Distance Bifocal No line Computer

Do you wear contact lenses Yes No If yes, what kind Disposable Gas Permeable

Contact lens brand _____ How old is your current pair _____

Please list all medications you take including oral contraceptives, aspirin and over-the counter medications and/or supplements

Please list all allergies to medications and any seasonal allergies _____

Are you currently being treated for any eye diseases No Yes _____

Have you had past ocular surgery or trauma No Yes _____

Are you pregnant: No Yes # of weeks _____ Are you nursing No Yes

Family History

Please note any family members with the following conditions

- Cataracts No Yes Who _____
- Crossed eyes No Yes Who _____
- Glaucoma No Yes Who _____
- Macular Degeneration No Yes Who _____
- Retinal Disease No Yes Who _____
- Diabetes No Yes Who _____
- Thyroid Disease No Yes Who _____

Review of Systems

Do you currently have problems in the following areas:

- | | | | |
|----------------------|--|-----------------------------|--|
| Integumentary (skin) | <input type="checkbox"/> No <input type="checkbox"/> Yes | Endocrine/Thyroid | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Neurological | | Cardiovascular | |
| Headaches/Migraines | <input type="checkbox"/> No <input type="checkbox"/> Yes | High blood pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Seizures | <input type="checkbox"/> No <input type="checkbox"/> Yes | CVA/Stroke | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ear/Nose/Throat | | Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Seasonal Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes | Average fasting blood sugar | _____ |
| Sinus Congestion | <input type="checkbox"/> No <input type="checkbox"/> Yes | Latest A1C | _____ |
| Respiratory/Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetic Retinopathy | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Gastrointestinal | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Genitourinary | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Bones/Joints | | | |
| Rheumatoid arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Joint pain | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Hematological | | | |
| Anemia | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Bleeding problems | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Psychiatric | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

Social History

- Do you smoke No Yes
How often/amount _____
- Do you drink alcohol No Yes
How often/amount _____
- Do you use illicit drugs No Yes

Eyes

Do you currently have problems in the following areas:

- | | | | |
|---------------------------|--|-------------------------|--|
| Blurred vision | <input type="checkbox"/> No <input type="checkbox"/> Yes | Itching | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Loss of side vision | <input type="checkbox"/> No <input type="checkbox"/> Yes | Burning | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Double vision | <input type="checkbox"/> No <input type="checkbox"/> Yes | Foreign body sensation | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dryness | <input type="checkbox"/> No <input type="checkbox"/> Yes | Glare/light sensitivity | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Watering/Discharge | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sties | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Redness | <input type="checkbox"/> No <input type="checkbox"/> Yes | Flashes of light | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sandy or gritting feeling | <input type="checkbox"/> No <input type="checkbox"/> Yes | Floater | <input type="checkbox"/> No <input type="checkbox"/> Yes |

HIPAA Notice of Privacy Practices

I hereby acknowledge that a copy of the Notices of Privacy Practices of Veld Vision Center has been made available to me.

Signature of patient or legal representative

Date