WELCOME TO VISION EXPERTS OPTOMETRY INC.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

PATIENT INFORMATION

Date____/____/_____

Last 4 digits of Social Security Number_____

Patient Name: First_____Last_____

Local Address_____City_____State_____Zip_____

Sex: ❑ Male ❑ Female Age_____ Birthdate_____/_____/_____

Home Phone_____-_____-_____ Cell Phone_____-_____-_____

Occupation? _____ Email Address_____

Insurance: VSP ☐ Anthem (EYEMED) ☐ United Healthcare (Spectera) ☐ Other_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____-_____-_____ Cell_____-_____-_____

How did you hear about us? Flyer ☐ Mailer ☐ Yelp ☐ Facebook ☐ Insurance Website ☐ Other _____

Who may we thank for your referral? _____

EYE HEALTH HISTORY

Date of last eye exam_____Name of doctor_____

Reason for visit:_____

Do you wear glasses? ❑ Yes ❑ No

❑ All the time ❑Occasionally ❑ Reading ❑ Driving ❑ TV

Do you wear contacts? ❑ Yes ❑ No Contact Lens Type: ❑Soft ❑RGP Brand:_____

Are you pregnant? ❑ Yes ❑ No If yes, how many months? _____

Have you had medically necessary eye surgery? Yes___No___ How long ago? _____Reason?_____

_____

Have you had laser eye surgery? Yes____No_____ How long ago?_____Reason?_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	❑ Yes ❑ No	Dry Eyes	❑ Yes ❑ No	Loss of Vision	❑ Yes ❑ No
Blurred Vision – Distance	❑ Yes ❑ No	Eye Infection	❑ Yes ❑ No	Migraine Headaches	❑ Yes ❑ No
Blurred Vision – Near	❑ Yes ❑ No	Eye Injury	❑ Yes ❑ No	Night Vision, Poor	❑ Yes ❑ No
Burning Eyes	❑ Yes ❑ No	Eye Strain	❑ Yes ❑ No	Red Eyes	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	Fainting Spells/Blackouts	❑ Yes ❑ No	Seeing Halos	❑ Yes ❑ No
Color Vision, Poor	❑ Yes ❑ No	Temporary Loss of Vision	❑ Yes ❑ No	Seeing Flashes	❑ Yes ❑ No
Crossed Eyes	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Floaters or Spots	❑ Yes ❑ No
Discharge from Eyes	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Twitching Eyelid	❑ Yes ❑ No
Dizzy Spells	❑ Yes ❑ No	Itching Eyes	❑ Yes ❑ No	Vision Poor	❑ Yes ❑ No
Double Vision	❑ Yes ❑ No	Light Sensitive	❑ Yes ❑ No	Watering Eyes	❑ Yes ❑ No

Other:_____

OVER

HEALTH HISTORY

Physician's Name_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	❑ Yes ❑ No	❑ Yes ❑ No	Heart Condition	❑ Yes ❑ No	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	❑ Yes ❑ No	Hepatitis (Type____)	❑ Yes ❑ No	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	❑ Yes ❑ No	Lazy Eye	❑ Yes ❑ No	❑ Yes ❑ No
Bleeding	❑ Yes ❑ No	❑ Yes ❑ No	Lupus	❑ Yes ❑ No	❑ Yes ❑ No
Blindness	❑ Yes ❑ No	❑ Yes ❑ No	Migraine Headaches	❑ Yes ❑ No	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	❑ Yes ❑ No	Poor Color Vision	❑ Yes ❑ No	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	❑ Yes ❑ No	Retinal Disease	❑ Yes ❑ No	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	❑ Yes ❑ No
Drug Sensitivity	❑ Yes ❑ No	❑ Yes ❑ No	Shingles	❑ Yes ❑ No	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	❑ Yes ❑ No	Skin Conditions	❑ Yes ❑ No	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	❑ Yes ❑ No	Stroke	❑ Yes ❑ No	❑ Yes ❑ No
Eye Surgery	❑ Yes ❑ No	❑ Yes ❑ No	Thyroid Conditions	❑ Yes ❑ No	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	❑ Yes ❑ No
Hay Fever	❑ Yes ❑ No	❑ Yes ❑ No	Turned Eye	❑ Yes ❑ No	❑ Yes ❑ No
Tobacco use	❑ Yes ❑ No	❑ Yes ❑ No	Alcohol use	❑ Yes ❑ No	❑ Yes ❑ No

Other:_____

_____

MEDICATIONS

Please list any medications that you are currently taking including over-the-counter, oral contraceptives, eye drops, etc.

_____

_____

_____

Herbal Vitamins:

_____

_____

ALLERGIES

Please state any known allergies or abnormal reactions to medications or other substances:

_____

_____

_____

_____

_____

_____

_____

NOTICE OF PRIVACY RIGHTS

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY RIGHTS

I hereby acknowledge that I have received a copy of AOA's Notice of Privacy Practices.

Patient Name _____

Signature_____Date_____