

Today's Date _____

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Work Phone _____
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____
 Patients Date of Birth _____ Age _____
 Sex M F
 Email Address _____
 What is the major purpose of this visit?

Any problems with your current contact lenses or glasses? _____

Who may we thank for referring you to our office?

Name of Friend or relative: _____

If not referred, how did you choose our office?

- Another Dr.
- Saw Sign/Building
- Yellow Pages: Which directory? _____
- Web site: Which Site? _____
- Insurance List?
- Newspaper?
- Other _____



WELCOME TO OUR OFFICE!

Insurance Information

***Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.**

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Do you participate in a flex spending account?
 Yes No

How will you settle your account today?

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sun wear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/ Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Family Physician _____		
Town _____		
Date of Last Physical Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____		

Allergies to medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what medications? _____		

Have you had any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use cigarettes/tobacco, alcohol, or other substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed or treated for the following health problems?	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind?	_____
Solutions used	_____
Are you satisfied with the vision and comfort of your contact lenses?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you wear bifocals, do the lines or head tilting bother you?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Advanced Family Eyecare. In the case of a lack of insurance payment, the billed amount will fall to the below signed responsible party.	
Responsible Party: _____	
Date: _____	

