



Office Use Only	
Update	Pt. Int.

## Welcome to Fenton Vision Center

**Patients Name** :Ms, Mrs, Mr, Dr.

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
 E-mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female MAY WE LEAVE ANY HEALTH RELATED HEALTH INFORMATION ON YOUR ANSWERING MACHINE/VOICEMAIL?  
 Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: Single Married Other YES NO

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**Whom may we thank for referring you to us?**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_

Do you have any insurance (vision or medical)? Yes No  
 If yes, please also complete the Insurance Information Sheet in full.

Person Financially Responsible:  
 Same as above) or Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Street Address:  Same as above) or \_\_\_\_\_  
 Phone# \_\_\_\_\_

Family physician name \_\_\_\_\_ Physician's phone number \_\_\_\_\_  
 Are you taking **ANY** medication? Yes No If yes, what is it, what's being treated, and how often do you take it? \_\_\_\_\_

Are you allergic to **ANY** medication(s)? Yes , No If yes, which medications? \_\_\_\_\_

Do you : Drink Alcohol? Yes No Smoke? Yes No Consume Illegal Drugs? Yes No

**Without any vision correction being used, do you suffer from any of the following:**

near vision blur	dry eyes
distance vision blur	watery eyes
middle distance vision blur (dashboard/computer)	pain in/around eyes
double vision	red eyes
headaches	changing focus from near to distance
seeing spots/lines	changing focus from distance to near
seeing flashes	outdoor glare
seeing haloes	indoor glare
	eye strain

Date of last eye exam \_\_\_\_\_ were your pupils dilated (drops) at your last examination? Yes , No  
 Date of last general examination \_\_\_\_\_ Do you use a computer? Yes , No If yes, \_\_\_ hrs/day \_\_\_ days/wk.  
 Special vision requirements (occupation/computer/hobbies/sports)? \_\_\_\_\_

Many diseases of the body have grave eye health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it is imperative we acquire an in depth medical history. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them. This information is also critical in the event we need to prescribe certain medications. OVER PLEASE

Do you or any **blood** relatives currently suffer from or have a history of:

	<u>SELF</u>		<u>FAMILY</u>			<u>SELF</u>		<u>FAMILY</u>	
	YES	NO	YES	NO		YES	NO	YES	NO
Glaucoma					High blood pressure				
Cataracts					Diabetes				
Amblyopia(lazy eye)					Multiple sclerosis				
Thyroid					Cardiac disease				
Color blindness					<b>Any</b> Cancer				
Retinal macular degeneration					Keratoconus				
Retinal detachments					Strabismus (crossed eye)				

	<u>SELF</u>			<u>SELF</u>			<u>SELF</u>	
	YES	NO		YES	NO		YES	NO
Major dental disease			Syphilis			Chronic renal failure		
Sinus problems			Shingles/herpes			History of thoracic surgery		
Allergies			Lyme disease			Seizures		
Arthritis			High cholesterol			Asthma		
Sarcoidosis			HIV			Emphysema		
Lupus			Mitral valve prolapse			Chronic bronchitis		
Psoriasis			Arteriosclerosis			Liver disease		
Crohn's disease			Graves/thyroid disease			Myasthenia gravis		
Ankylosing Spondylitis			Chronic obstructive pulmonary disease			Stevens Johnson Syndrome		
Reiters syndrome								

Do you suffer from **Any** diseases not listed above? Yes  , No  If yes, what disease(s) \_\_\_\_\_

If you currently wear eyeglasses, does your spare pair have your correct prescription? Yes  , No

If you currently wear prescription sunglasses, do they have UV (Ultra-Violet) protection? Yes  , No  , Not Sure

If you currently wear eyeglasses, are there certain times when you would rather not? (for example-sports, business presentations, social occasions etc.) Yes  , No

If you currently wear contact lenses, do your backup eyeglasses have your correct prescription? Yes  , No

Have you had any surgeries performed? Yes  No  If yes, please describe: \_\_\_\_\_

Would you like to be evaluated for surgery to correct your vision? Yes  , No

Would you like to be evaluated for a NON-surgical method to correct your vision? Yes  , No

Have you **ever** worn contact lenses? Yes  , No

If yes, check all that apply even if worn for only a short time:  
soft  , hard  , gas permeable  , daily wear  , extended wear  ,  
disposable  , monovision  , tinted  , bifocal  , planned replacement

I certify that the above is true and correct. I authorize the release of any information including the diagnosis and the records of any treatment or examination of myself or my child to third party payers and/or health care practitioners. Further, I agree to assume prompt financial responsibility for any unpaid balances including unpaid insurance balances.

**X** \_\_\_\_\_ Date \_\_\_\_\_