HIGHLANDS EYECARE **Vision Source!®**

WELCOME TO OUR OFFICE

Today's Date _____

Name: _____ Sex: Male Female Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell/Mobile # _____

Soc. Sec # _____ Referred to us by _____

Employer Name: _____ Employer Address: _____

Name of Spouse: _____ Name of Spouses Employer _____

Emergency Contact: Name: _____ Relation: _____ Phone: _____

Name of Vision Insurance _____ Group # _____ Member ID# _____

Person Responsible for Payment (Guarantor) _____ Relation to Patient _____

Name of Family Physician _____ Medical Insurance Carrier _____

Email: _____

MEDICAL HISTORY

Do you have allergies to medication? No / Yes Eyes, explain: _____

List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury, laser surgery or other (please explain): _____

Are you pregnant and/or nursing? No / Yes

Last eye examination: _____

Do you wear glasses? No / Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No / Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses, rigid / soft extended wear / other _____ Are they comfortable? No / Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

DISEASE / CONDITION		RELATIONSHIP TO YOU
☐ Blindness	No / Yes / Don't Know	_____
☐ Cataract	No / Yes / Don't Know	_____
☐ Crossed Eyes	No / Yes / Don't Know	_____
☐ Glaucoma	No / Yes / Don't Know	_____
☐ Macular Degeneration	No / Yes / Don't Know	_____
☐ Retinal Detachment / Disease	No / Yes / Don't Know	_____
☐ Arthritis	No / Yes / Don't Know	_____
☐ Cancer	No / Yes / Don't Know	_____
☐ Diabetes	No / Yes / Don't Know	_____
☐ Heart Disease	No / Yes / Don't Know	_____
☐ High Blood Pressure	No / Yes / Don't Know	_____
☐ Kidney Disease	No / Yes / Don't Know	_____
☐ Lupus	No / Yes / Don't Know	_____
☐ Thyroid Disease	No / Yes / Don't Know	_____
☐ Other _____	No / Yes / Don't Know	_____

MEDICAL HISTORY (SELF)

CONSTITUTIONAL	
Fever, Weight Loss / Gain	NO / YES / ?
INTEGUMENTARY (Skin)	NO / YES / ?
NEUROLOGICAL	
Headaches	NO / YES / ?
Migraines	NO / YES / ?
Seizures	NO / YES / ?
EYES	
Dryness	NO / YES / ?
Redness	NO / YES / ?
Sandy or Gritty Feeling	NO / YES / ?
Burning	NO / YES / ?
Foreign body Sensation	NO / YES / ?
Excess Tearing / Watering	NO / YES / ?
Mucous Discharge	NO / YES / ?
Itching	NO / YES / ?
Glare / Light Sensitivity	NO / YES / ?
Eye Pain or Soreness	NO / YES / ?
Loss of Vision	NO / YES / ?
Blurred Vision	NO / YES / ?
Distorted Vision / Halos	NO / YES / ?
Loss of Side Vision	NO / YES / ?
Double Vision	NO / YES / ?
Chronic Infections	NO / YES / ?
Styes or Chalazia	NO / YES / ?
Flashes / Spots in Vision	NO / YES / ?
Tired Eyes	NO / YES / ?
ENDOCRINE	
Thyroid / Other Glands	NO / YES / ?

EARS, NOSE, MOUTH, THROAT	
Allergies / Hay Fever	NO / YES / ?
Sinus Congestion	NO / YES / ?
Runny Nose	NO / YES / ?
Post Nasal Drip	NO / YES / ?
Chronic Cough	NO / YES / ?
Dry Throat / Dry Mouth	NO / YES / ?
RESPIRATORY	
Asthma	NO / YES / ?
Chronic Bronchitis	NO / YES / ?
Emphysema	NO / YES / ?
VASCULAR / CARDIOVASCULAR	
Diabetes	NO / YES / ?
Heart Pain	NO / YES / ?
High Blood Pressure	NO / YES / ?
Vascular Disease	NO / YES / ?
GASTROINTESTINAL	
Crohn's Disease	NO / YES / ?
Other	NO / YES / ?
GENITOURINARY	
Genitals / Kidney / Bladder	NO / YES / ?
BONES / JOINTS / MUSCLES	
Arthritis	NO / YES / ?
Muscle Pain	NO / YES / ?
Joint Pain	NO / YES / ?
LYMPHATIC / HEMATOLOGIC	
Anemia	NO / YES / ?
Bleeding Problems	NO / YES / ?
ALLERGIC/ IMMUNOLOGIC	NO / YES / ?
PSYCHIATRIC	NO / YES / ?
HIV / AIDS	NO / YES / ?

What is your occupation? _____

What are your hobbies? _____

Do you use a computer regularly? Y / N

Are you interested in laser vision correction? Y / N

Are you interested in contact lenses? Y / N

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection of fees, including reasonable attorney fees, and applicable court costs in addition to my outstanding balance. I understand that my insurance company has a contract with me. Should insurance not pay the contracted amount to this office, I understand that my balance is my responsibility. The policy of this office is that payment is expected at the time services are rendered.

Signed _____ ***Date*** _____