VISIONAIRE
EYECARE
EYECARE THE WAY IT SHOULD BE

Patient Information

Full Name:_____ DOB:_____ Sex: **M** / **F** Date:_____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Occupation:_____

E-mail: _____

Who referred you to us? Name: _____ Phone: _____

Medical Information

Reason for today's exam:_____

Are you experiencing any medical problems with your eyes (i.e. dry eyes, itchy eyes, etc.) that you would like addressed?

Y / **N** If YES, please explain_____

Are you pregnant and/or nursing? **Y** / **N**

Allergies to any medications or Latex?_____

Do you wear contact lenses (CL)? **Y** / **N** Contact Lens info: **Soft** / **Hard** CL Brand:_____

Cleaning Solution:_____ How often do you sleep in your CL?_____

Do you have any systemic medical condition that may impact your eyes or vision such as **HIGH BLOOD PRESSURE and/or DIABETES**? **Y/ N** If YES, please tell us immediately. _____

Have you ever had an INFECTION, INJURY, or SURGERY affecting the **EYES** or **HEAD**? Please explain._____

_____

Are your eyes sensitive to sunlight? **Y** / **N** Do you have problems with reflections and/or glare? **Y** / **N**

Do you sometimes experience dry eyes? **Y** / **N** Do you use digital devices i.e. computers, smart phones, HDTV's? **Y** / **N**

Do you prefer not to wear your glasses at times? **Y** / **N** Would you be interested in newer contact lens technology? **Y** / **N**

Would you be interested in LASIK vision surgical correction? **Y** / **N** Be interested in a *non-surgical* option to LASIK? **Y** / **N**

Please list your sports activities and hobbies _____

_____

Medical / Vision Insurance Information—If applicable (Please provide insurance card(s) to photocopy)

Name of Insured_____ Relation to Insured_____

Date of Birth of Insured_____ ID # of Insured_____

Medical/Vision Insurance Carrier_____ Insurance Group Number_____

I authorize Visionaire Eyecare to submit billing to my insurance company when applicable and I understand I may be responsible for any charges not covered by insurance.

_____

Signature of Patient or Representative

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Current medications (if you have a list of medications, please give it to the receptionist):_____

_____

Primary Care Physician:_____

Conditions you are currently being **TREATED** for:_____

Past **MEDICAL** conditions and/or **SURGERIES**:_____

Are you **EXPERIENCING** or have been **DIAGNOSED** and/or **TREATED** for any of the following below?
Please **CHECKMARK** under YES/NO.

YES	NO	If **YES**, please **CIRCLE** the disease/symptom.
		Eyes: (Please CIRCLE which eye and EXPLAIN if applicable) ▪ Crossed Eye / Eye Turn **(R / L / Both)**_____ ▪ Double Vision **(R / L / Both)**_____ ▪ Dry Eyes **(R / L / Both)**_____ ▪ Eye Infections **(R / L / Both)**_____ ▪ Excess Tearing / Watering **(R / L / Both)**_____ ▪ Flashes of Light / Floaters **(R / L / Both)**_____ ▪ Glaucoma **(R / L / Both)**_____ ▪ Itchy Eyes **(R / L / Both)**_____ ▪ Lazy Eye **(R / L / Both)**_____ ▪ Macular Degeneration **(R / L / Both)**_____ ▪ Retinal Detachment or Disease **(R / L / Both)**_____ ▪ Tired Eyes / Eyestrain **(R / L / Both)**_____ ▪ Other Eye Disorders **(R / L / Both)**_____
		Constitutional: ▪ Fever ▪ Fatigue ▪ Unintended Weight Gain or Loss ▪ Other_____
		Ear, Nose, & Throat: ▪ Allergies ▪ Dry Throat / Mouth ▪ Hearing Loss ▪ Laryngitis ▪ Sinus Congestion
		Cardiovascular: ▪ Congestive Heart Failure ▪ Heart attacks ▪ High Blood Pressure ▪ Vascular Disease ▪ Other_____
		Respiratory: ▪ Asthma ▪ Bronchitis ▪ Lung Cancer ▪ Sleep Apnea ▪ Other_____
		Gastrointestinal: ▪ Celiac Disease ▪ Colitis ▪ Crohn's Disease ▪ Kidney Disease ▪ Stomach Ulcer ▪ Other_____
		Musculo-skeletal: ▪ Ankylosing Spondylitis ▪ Arthritis ▪ Fibromyalgia ▪ Gout ▪ Muscular Dystrophy ▪ Osteoporosis ▪ Rheumatoid Arthritis ▪ Other_____
		Skin: ▪ Cold sores ▪ Eczema ▪ Rosacea ▪ Shingles ▪ Skin Disease ▪ Other_____
		Endocrine: ▪ Diabetes (Type 1 / 2) ▪ Hormone Replacement ▪ Thyroid disorder ▪ Other_____
		Neurological: ▪ Cerebral Palsy ▪ Headaches / Migraines ▪ Multiple Sclerosis ▪ Seizures / Epilepsy ▪ Other_____
		Psychiatric: ▪ Anxiety ▪ Bipolar Disorder ▪ Depression ▪ Other_____
		Blood & Lymph: ▪ Anemia ▪ HIV / AIDS ▪ High Cholesterol ▪ Other_____

YES	NO	FAMILY HISTORY:
		Does a BLOOD relative in your family have any of the following diseases? (**CIRCLE** all that apply) ▪ Cancer (Type:_____) ▪ Cataracts ▪ Diabetes ▪ Glaucoma ▪ High Blood Pressure ▪ Stroke ▪ Thyroid Disease ▪ Macular Degeneration ▪ Other _____
YES	**NO**	**SOCIAL HISTORY:**
		Does your current vision **LIMIT** any activities of your daily living? (**CIRCLE** all that apply) ▪ Driving ▪ Reading ▪ Sports ▪ Work ▪ Other _____
		Do you drink alcohol?
		Do you smoke? If **YES**, how much? _____ per day; how long? _____ year(s)