VISION One
Clearly a Difference...

Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **Patient ID:**

Last Name | Middle | First Name | Suffix | Preferred | DOB (mm/dd/yy) | SSN

Patient's Address | **Address Line 2** | Primary Phone ☐ Home ☐ Mobile | Day/Work Phone

City | State | Zip | Country | Emergency Contact | Emergency Phone

Email | Person responsible for this account

Other person authorized to discuss health info Name

Relationship to patient

Sex ☐ Male ☐ Female | **Occupation/Grade** | **Employer/School**

Primary Physician

☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N.

First Name | Middle | Last Name | Suffix | Clinic Name

Primary Insurance

Insured's Name (First Name, Middle Initial, Last Name)

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance

Insured's Name (First Name, Middle Initial, Last Name)

Insured's ID No | Group No | Insured's DOB | Sex ☐ M ☐ F

Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you initially find our office?

Health History

Reason for today's exam

When was your last eye exam? | When was your last health exam?

Past illnesses or injuries

Past surgeries / Eye surgeries

Current eye drops

Current medications

Reactions/sensitivities medicines

Specific allergies

Current Eye Symptoms

Glare Sensitivity	☐ Yes ☐ No	Foreign Body Sensation	☐ Yes ☐ No	Distorted Vision (Halos)	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Infection of Eye or Lid	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No
Light Sensitivity	☐ Yes ☐ No	Itching	☐ Yes ☐ No	Flashes	☐ Yes ☐ No
Tired Eyes	☐ Yes ☐ No	Mucous Discharge	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Burning	☐ Yes ☐ No	Drooping Eyelid	☐ Yes ☐ No	Fluctuating Vision	☐ Yes ☐ No
Dryness	☐ Yes ☐ No	Redness	☐ Yes ☐ No	Loss of Central Vision	☐ Yes ☐ No
Excess Tearing/Watering	☐ Yes ☐ No	Sandy or Gritty Feeling	☐ Yes ☐ No	Loss of Side Vision	☐ Yes ☐ No
Eyelid Swelling	☐ Yes ☐ No	Blurred Vision Distance	☐ Yes ☐ No	Loss Of Vision	☐ Yes ☐ No
Eye Pain or Soreness	☐ Yes ☐ No	Blurred Vision Near	☐ Yes ☐ No	Other	☐ Yes ☐ No

Eye History

Amblyopia (Lazy Eye)	☐ Yes ☐ No	Dry Eye Syndrome	☐ Yes ☐ No	PVD (Vitreous Detachment)	☐ Yes ☐ No
Infection of Eye or Lid	☐ Yes ☐ No	Eye Injuries	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Crossed Eyes	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Glaucoma Suspect	☐ Yes ☐ No	Keratoconus	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	High Risk Medication	☐ Yes ☐ No	Corneal Disease	☐ Yes ☐ No
Diabetic Retinopathy	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No	Other	☐ Yes ☐ No

General Health Condition

Fever, Weight Loss, Fatigue, etc	☐ Yes ☐ No	Kidney, Bladder issues	☐ Yes ☐ No	Thyroid, Diabetes	☐ Yes ☐ No
Ears, Nose, Throat issues	☐ Yes ☐ No	Muscles, Bones, Joints issues	☐ Yes ☐ No	Blood (Cholesterol, Anemia, etc)	☐ Yes ☐ No
Cardiovascular (High BP etc.)	☐ Yes ☐ No	Skin (Rash, Itching, etc)	☐ Yes ☐ No	Allergic, Immuno	☐ Yes ☐ No
Respiratory (Asthma)	☐ Yes ☐ No	Neurological (Multiple Sclerosis)	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Gastrointestinal	☐ Yes ☐ No	Anxiety or Depression	☐ Yes ☐ No	Nursing	☐ Yes ☐ No

Family History

Amblyopia (Lazy Eye)	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Cataract(s)	☐ Yes ☐ No	Strabismus (Eye Turn)	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Eye Tumors	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Others	☐ Yes ☐ No
Glaucoma Suspect	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No		

Social History

Do you drink alcohol? ☐ No ☐ Occasional ☐ 1 Per Day ☐ 2-3 Per Day ☐ 4+ Per Day

Tobacco use / smoking frequency?

Do you use recreational drugs? ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Use nutritional supplements (vitamins etc.)? ☐ Yes ☐ No

Hobbies/Interests

Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)

☐ Safety glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots)

☐ Sports/Hobbies (racquet sports, motorcycle)

Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Reason for stopping?

Do you currently wear contact lenses? ☐ Yes ☐ No

Since

Type and brand of contact lenses

How many days/week?

How many hours/day?

Today's Wearing Time

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Vison One. I understand that my primary insurance will be billed. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____