

PATIENT INFORMATION FORM

DATE: _____

PLEASE PRINT

PATIENT INFORMATION				
TITLE	NAME			
MISS MR. MRS. MS. OTHER _____	LAST	FIRST	MI	
MAILING ADDRESS	ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	HOME ()	WORK ()	CELLULAR ()	EMAIL ADDRESS
BIRTH DATE / /	SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	PATIENT SS# / /	OCCUPATION	INTERESTS/ACTIVITIES
PATIENT SIGNATURE (PARENT/GUARDIAN FOR PATIENT UNDER 18 YEARS OLD)				
INSURANCE INFORMATION				
<input type="checkbox"/> VSP <input type="checkbox"/> MES <input type="checkbox"/> EYEMED <input type="checkbox"/> _____ RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____				
EMERGENCY CONTACT				
IN CASE OF EMERGENCY, PLEASE CONTACT:				
NAME _____		RELATIONSHIP _____		
HOME PHONE: ()		WORK PHONE: ()		CELL PHONE: ()

Reason for visit:
_____ _____ _____ _____ _____
Date of last eye exam: _____

Eye Health History		
Do you wear glasses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how often?	<input type="checkbox"/> All day	<input type="checkbox"/> Occasionally
	<input type="checkbox"/> Driving	<input type="checkbox"/> Reading
	<input type="checkbox"/> Computer	<input type="checkbox"/> TV/Movies
Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type: <input type="checkbox"/> Gas Perm <input type="checkbox"/> Soft	Hours per day: _____	
Check the box next to any of the symptoms/conditions you have had:		
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Burning Eyes	<input type="checkbox"/> Discharge
<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Migraine
<input type="checkbox"/> Light Sensitive	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Headache
<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Blurred Distance Vision
<input type="checkbox"/> Watery Eyes	<input type="checkbox"/> Seeing Halos	<input type="checkbox"/> Blurred Near Vision
<input type="checkbox"/> Twitching Eyelid	<input type="checkbox"/> Headaches	<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Seeing Flashes	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Near Vision
<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Poor Night Vision	

General Health History					
Primary Physician's Name: Dr. _____			Date of Last Visit: _____		
List all medications you are taking, including eye drops: _____ _____					
List your allergies to medications and other substances: _____					
Check appropriate boxes to indicate if you and/or your family members have any of these conditions:					
Condition	Self	Family	Condition	Self	Family
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Other:		
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis: _____	<input type="checkbox"/>	<input type="checkbox"/>			
Are you pregnant:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco use:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol use:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug use:				<input type="checkbox"/> Yes	<input type="checkbox"/> No

How did you hear about us? Walk-in VSP Patient Referral _____ Mailing Online/Yelp Other _____
