

To comply with medical record requirements, please complete the following information.

Dr. Prof. Rev.

Name Mr. Mrs. Ms. \_\_\_\_\_ Gender M F Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 \_\_\_\_\_ Occupation \_\_\_\_\_  
 Phone \_\_\_\_\_ (h) \_\_\_\_\_ (w) Hobbies \_\_\_\_\_  
 Name of Parent or Spouse \_\_\_\_\_ Children \_\_\_\_\_  
 E-mail address (optional) \_\_\_\_\_ Last Eye Exam \_\_\_\_\_  
 Name of Primary Medical Doctor \_\_\_\_\_ Last Medical Exam \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_ Payment method for account? Cash/Check Visa/MC  
 Insurance (name of company) \_\_\_\_\_ Social Sec. No. \_\_\_\_\_

**What is your reason for today's eye exam?** Please mark all that apply and indicate time / duration of event.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> blur at distance   | <input type="checkbox"/> glaucoma                           | <input type="checkbox"/> eye pain / discomfort |
| <input type="checkbox"/> blur at near       | <input type="checkbox"/> lazy eye (amblyopia or strabismus) | <input type="checkbox"/> itching               |
| <input type="checkbox"/> double vision      | <input type="checkbox"/> red eyes                           | <input type="checkbox"/> broken glasses        |
| <input type="checkbox"/> computer strain    | <input type="checkbox"/> flashes of light                   | <input type="checkbox"/> floating spots        |
| <input type="checkbox"/> headache           | <input type="checkbox"/> tears / discharge                  | <input type="checkbox"/> want contact lenses   |
| <input type="checkbox"/> refractive surgery | <input type="checkbox"/> vision therapy                     | <input type="checkbox"/> dry eye               |

Other: \_\_\_\_\_

Have you had an eye injury?  no  yes if yes, explain: \_\_\_\_\_  
 Have you had eye surgery?  no  yes if yes, explain: \_\_\_\_\_

**If you currently have glasses or contact please complete below if not skip to next section:**

How old are your current glasses? \_\_\_\_\_  
 How old are you current contact lenses? \_\_\_\_\_  
 What type of contacts do you wear?  hard  soft  disposable  other  
 How often do you wear your lenses? \_\_\_\_\_ days of week \_\_\_\_\_ max. hours per day  
 What solution / care system do you use? \_\_\_\_\_  
 Do you / have you ever slept in your contacts? \_\_\_\_\_

**Medical History**

Do you have, or have you ever been treated for:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> arthritis / joint pain       | <input type="checkbox"/> breathing problems   |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney / urinary             | <input type="checkbox"/> depression / anxiety |
| <input type="checkbox"/> heart disease       | <input type="checkbox"/> sexually transmitted disease | <input type="checkbox"/> sinus / allergy      |
| <input type="checkbox"/> stroke              | <input type="checkbox"/> cancer                       | <input type="checkbox"/> skin condition       |
| <input type="checkbox"/> stomach problems    | <input type="checkbox"/> HIV                          | <input type="checkbox"/> hearing loss         |
| <input type="checkbox"/> thyroid / glands    | <input type="checkbox"/> headache / migraines         | <input type="checkbox"/> muscle weakness      |
| <input type="checkbox"/> dizziness / vertigo | Other: _____  |   |

Do you take **any medications** (pills or eye drops)?  no  yes If yes please list all or ask receptionist to copy your list.

Are you allergic to any medications?  no  yes If yes, list: \_\_\_\_\_  
 Are you pregnant or nursing?  no  yes  
 Do you smoke?  no  yes How much? \_\_\_\_\_  
 Do you drink alcohol?  no  yes How much? \_\_\_\_\_  
 Do you have a history of recreation drug use?  no  yes Type? \_\_\_\_\_

**Family Medical History:** Please mark the people in your family who have the following medical problems:

|                 |                            |                           |
|-----------------|----------------------------|---------------------------|
| diabetes _____  | high blood pressure _____  | sickle cell disease _____ |
| arthritis _____ | heart disease _____        | blindness _____           |
| glaucoma _____  | macular degeneration _____ | crossed eyes _____        |
| Other _____     |                            |                           |

# VisionQuest Eyecare

*Signature on file*

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Social Security No. \_\_\_\_\_

- I understand that I am responsible for my bill
- I authorize use of this form on all my insurance submissions
- I authorize release of information to all my insurance companies
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance company
- I authorize payment direct to my doctor
- I permit a copy of this authorization to be used in place of the original
- I acknowledge that I received a copy of the notice of privacy practices that describes how my medical information may be used

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

How will you settle your account today?

Cash  Check  Visa / Master  Insurance  Payment Plan