VISION SOURCE® OF MT. OLIVE

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WELCOME TO OUR OFFICE:

Today's Date:

Mr._____ Mrs._____ Ms._____ Miss_____ Dr.____

First:_____ Last:_____ MI:_____

Date of Birth:___/___/_____ Age____ Sex M F

Street:_____

City:_____State:____Zip code:_____

Home number:_____

Work number:_____Cell:_____

Preferred number for contact? H W C

Email address:_____

Social Security number:_____

Employer:_____

Occupation:_____

Emergency contact:

Name:_____Phone:_____

Relationship to contact:_____

Is this your first visit to our office?_____

Who can we thank for referring you to our office today?

_____

If you were not referred, how did you hear about our office?

_____

Please tell us why you are here today?

☐ Exam ☐ Glasses ☐ Contacts ☐ Infection or injury

☐ Medical problem ☐ Laser Vision Correction

☐ Other:_____

Medical Insurance : Policy Number:

_____

Subscriber:_____

Subscriber Social Security #_____

Subscriber Date of birth_____

Vision Insurance:_____

Subscriber:_____

Subscriber Social Security #_____

Subscriber Date of birth_____

Name of family physician_____

Address_____

Last visit_____

MEDICAL HISTORY:

Please circle all that apply to let us help you better:

EYE HISTORY:

Headaches	Glare light sensitivity	Tired eyes
Eye infection	Excessive tearing/watering	Redness
Lazy eye	Sandy or gritty feeling	Itching
Crossed eyes	Foreign body sensation	Dryness
Loss of vision	Retinal detachment	Burning
Double vision	Diabetic retinopathy	Glaucoma
Color blindness	Macular degeneration	Cataract(s)
Floaters	Blurred distance vision	Stye
Flashes	Blurred near vision	Eye pain
Other:		

GENERAL HEALTH:

Kidney	Muscles, bones, joints	Neurological
Endocrine	Ears, nose and throat	Psychiatric
Skin	Respiratory (asthma)	Diabetes
Allergic	Cardiovascular disease	Thyroid
Arthritis	High Blood Pressure	Blood/lymph
Stroke	Genital/urinary/bladder	AIDS/HIV
Cancer	High Cholesterol	Other:

FAMILY EYE AND MEDICAL HISTORY:

Blindness	Cataract	Glaucoma	Cancer
Diabetes	Macular Degeneration		Heart Disease
Arthritis	High blood pressure		Kidney

List all medications and vitamins and/or birth control pills

_____

_____

_____

Allergies to medications?_____

_____

Date of last eye exam?_____

Doctor?_____

Do you currently wear contacts?_____

If NO - are you interested?_____

Solution used_____

There is an additional fee to evaluate your contact lenses.

This fee is not usually covered by your managed care plans.

I want my current contacts evaluated:_____

please initial here