

**PREMIER VISION — PATIENT HISTORY**

1st update: \_\_\_\_\_ 2nd update: \_\_\_\_\_ 3rd update: \_\_\_\_\_ 4th update: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Patient Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

If interested in receiving offers & notices via email, provide address: \_\_\_\_\_

Date & place of last eye exam: \_\_\_\_\_ Marital Status: S M D W

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Physician's phone: \_\_\_\_\_

New Patients: Who may we thank for referring you to our practice? \_\_\_\_\_ If not referred, how did you choose our practice? \_\_\_\_\_

Insurance information:	Carrier	Subscriber Name	Social Security No. or Subscriber ID	Date of birth
Vision Insurance				
Medical Insurance				

**Social History:** What are your extracurricular visual needs? (Be specific: golf, fishing, hobbies, etc) \_\_\_\_\_

Do you smoke? No  Yes  How much? \_\_\_\_\_ Do you drink? No  Yes  How much? \_\_\_\_\_

**Describe here any history of fainting:**

EYE HISTORY		YES	NO
Work on a computer? If so, how many hours per day:			
Have eye strain and fatigue while on the computer?			
Do you experience glare from sunlight or artificial light?			
Do you sometimes experience dry eye? If so, list what you've done to treat it:			
<b>Rate your dry eyes:</b> <input type="checkbox"/> occasional <input type="checkbox"/> frequent <input type="checkbox"/> most of the time <b>Discomfort level:</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Wear sunglasses on a consistent basis?			
Rate your satisfaction with current glasses: <input type="checkbox"/> Extremely satisfied <input type="checkbox"/> Very <input type="checkbox"/> Somewhat <input type="checkbox"/> Not very <input type="checkbox"/> Not at all			
Wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, are you interested in wearing them? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, are you satisfied with your vision? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, are you satisfied with the comfort? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have a backup pair of prescription glasses?			
Have you considered laser vision correction or corrective eye surgery?			
Would you be interested in a no-charge consultation on laser vision correction / corrective eye surgery?			
Have children? No <input type="checkbox"/> Yes <input type="checkbox"/> If so, have they had an eye exam in the last year?			

Do you have a history of any of the following? (Please check all that apply.)  
 Lazy Eye  Eye Injury  Glaucoma  Macular Degeneration  Retinal Detachment  Cataracts  Other

MEDICATIONS	Short term Meds	Ongoing Meds	Dosage:	Date of any dosage changes	Describe change to dosage	Medication Discontinued	Updating:	Include your initials for updates
List below or if none, check here: <input type="checkbox"/>	List start / end dates.	List start date				indicate date	If updating, indicate date	

<b>LIST MEDICATION ALLERGIES:</b> If none, check here <input type="checkbox"/>	Description of Allergic Reaction

**Allergic to Latex?**     **Yes**     **No**

**HEALTH HISTORY** Please list surgeries, hospitalizations, significant treatments including dates and doctors.

1.	2.
3.	4.
5.	6.

<i>Do You currently have any problems in the following areas? If yes, please provide information.</i>	Yes	No	DETAILS
<b>General / constitutional</b> (fever, weight loss or gain, other)			
<b>Ear, Nose, Throat</b> (sinus problems, ear infection, cough, dry mouth, etc)			
<b>Cardiovascular</b> (high blood pressure, heart attack, heart disease, etc)			
<b>Respiratory</b> (asthma, bronchitis, emphysema, COPD, congestions, etc)			
<b>Gastrointestinal</b> (crohn's disease, GERD, stomach upset, diarrhea, constipation, etc.)			
<b>Genital, Kidney, Bladder</b> (kidney disease, painful or frequent urination, impotence, prostate, etc.)			
<b>Muscles, bones, joints</b> (arthritis, back pain, joint pain, stiffness, swelling, cramps, etc)			
<b>Skin</b> (cancer, rosacea, psoriasis, eczema, seborrhea, pimples, warts, growths, rash, etc)			
<b>Neurological</b> (stroke, alzheimers, migraines, MS, numbness, headache, etc)			
<b>Psychiatric</b> (anxiety, depression, insomnia, etc)			
<b>Endocrine</b> (diabetes, thyroid disorders, etc)			
<b>Allergic / Immunologic</b> (sneezing, swelling, redness, itching, hives, seasonal allergies, autoimmune disorders, etc)			
<b>Blood / Lymph</b> (high cholesterol, anemia, cancer, etc)			

<b>FAMILY HISTORY</b>	YES	NO	RELATIONSHIP TO PATIENT
Cataracts			
Glaucoma			
Macular Degeneration			
Cancer			
Diabetes			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

Patient Signature: \_\_\_\_\_  
 1st Update Patient Signature: \_\_\_\_\_  
 2nd Update Patient Signature: \_\_\_\_\_  
 3rd Update Patient Signature: \_\_\_\_\_  
 4th Update Patient Signature: \_\_\_\_\_

