WELCOME TO VISION SOURCE

OUR MISSION: To enhance your quality of life by providing the most comprehensive eye care through vision improvement and preservation of eye health.

OUR COMMITMENT: To provide superior VALUE and QUALITY eye health care through continuing education and technology.

Date: _____

PATIENT INFORMATION

Name: _____
LAST FIRST MI

Address: _____
STREET CITY STATE ZIP

Birth Date: _____ Age: _____ Sex: M F

Tele: _____
HOME CELL WORK

SSN: _____ Marital Status: S M D W

Email: _____

Employer/School: _____

Occupation/Grade: _____

Spouse/Parent Name: _____

Spouse/Parent Employer: _____

Spouse/Parent Tele: _____

LIFESTYLE QUESTIONS

DO YOU . . . check box if answer is YES

- ☐ . . work at a computer? How much _____Hrs/Day
- ☐ . . think you might benefit from thinner, lighter lenses?
- ☐ . . want a "trial" of the latest contact lens designs?
- ☐ . . spend time outdoors? How much? _____Hrs/Week
- ☐ . . have prescription sun wear?
- ☐ . . prefer not to wear your glasses at times?
- ☐ . . want info on Laser Vision Correction Surgery?
- ☐ . . have interest in non-surgical Vision Correction?
- ☐ . . have more than 1 pair of current Rx eyewear?
- ☐ . . have children?
- ☐ . . have family members in need of eye care?

What is the major purpose of this visit?

_____

NEW PATIENTS: VERY IMPORTANT!!

Who may we thank for referring you to our office? _____

If not referred, how did you choose our office?

- ☐ Newspaper/Radio/TV ☐ Insurance List
- ☐ Yellow Pages: Which One: _____
- ☐ Website: Which One: _____
- ☐ Other: _____

PATIENT EYE HISTORY

Date of Last Eye Exam: _____
Clinic/Dr. Name: _____

Do you wear Glasses: No Always Sometimes
Work Only Reading Only Driving Only

Age of current glasses? _____

If you wear bi-focal lenses, do the lines or head tilting bother you? YES NO

Have you ever tried Contact Lenses? YES NO

Do you currently wear contact lenses? YES NO

What kind: _____ Daily Overnight
Solutions Used: _____
Replacement Schedule: Daily 2wk Mthly Yrly

Are you satisfied with the VISION and COMFORT of your contact lenses? YES NO

Contact Lense Preference: CLEAR COLORED

WHAT ARE YOUR VISUAL SYMPTOMS : Please circle (Right Left Both)

Blurred Vision/Far	R L B	Itchy Eyes	R L B	Headaches	R L B
Blurred Vision/Near	R L B	Dry Eyes	R L B	Migraine Headaches	R L B
Double Vision	R L B	Red Eyes	R L B	Loss of Vision	R L B
Poor Night Vision	R L B	Watery Eyes	R L B	Crossed Eyes	R L B
Eye Strain	R L B	Mucus Discharge	R L B	Light Sensitive	R L B
Eye Infections	R L B	Wandering Eye	R L B	Sandy/Gritty Feeling	R L B
Eye Pain/Soreness	R L B	Sees Floaters/Spots	R L B	Poor Color Vision	R L B
Tired Eyes	R L B	Sees Flashes	R L B	Droopy Lid	R L B
Burning Eyes	R L B	Sees Halos	R L B		

OVER ➜

PATIENT MEDICAL HISTORY

PLEASE ✔ IF ANY OF THE FOLLOWING APPLIES TO YOU. IF DOESN'T APPLY PLEASE ✔ NONE

CARDIOVASCULAR: ___ NONE	**ENDOCRINE:** ___ NONE	**RESPIRATORY:** ___ NONE
Hypertension Stroke Heart Disease Vasular Disease Other:	Diabetes: Non-Insulin Dependent Diabetes: Insulin Dependent Thyroid Problem Hormonal Dysfunction Other:	Asthma Bronchitis Emphysema COPD Other:
CONSTITUTIONAL: ___ NONE	**DERMATOLOGIC:** ___ NONE	**PSYCHIATRIC:** ___ NONE
Cancer Trauma/LG Volume Blood Loss Developmental Disability Other:	Eczema Rosacea Psoriasis Other:	ADHD Depression Schizophrenia Anxiety Other:
NEUROLOGICAL: ___ NONE	**MUSCULOSKELETAL:** ___ NONE	**IMMUNOLOGIC:** ___ NONE
Multiple Sclerosis Epilepsy Cerebral Palsy Tumor Other:	Osteo-Arthritis Fibromyalgia Muscular Dystrophy Ankylosing Spondylitis Other:	AIDS or HIV Rheumatoid Arthritis Lupus Neurofibromatosis Other:
HEMATOLOGICAL: ___ NONE	**GASTROINTESTINAL:** ___ NONE	**EAR/NOSE/THROAT:** ___ NONE
Anemia Leukemia Cholesterol Other:	Crohn's Disease Colitis Other:	Hearing Loss Upper Respiratory Infection Other
OCULAR: ___ NONE	**ALLERGIES: Drug and Environmental** ___ NONE	
Glaucoma Macular Degeneration Detached Retina Corneal Abrasions Lazy Eye Iritis/Uveitis Other:	Please include physical reactions to lists allergies below:	

Alcohol Use: Y N Amount: _____ **Tobacco Use: Y N Amount:** _____

Patient Current Medical Activity

Date of Last Medical Exam: _____
Primary Physician/Clinic: _____
Eye Injuries: Y N Which Eye: R L
When: _____
Eye Surgeries: Y N Which Eye: R L
When: _____
Pregnant or Nursing: Y N

LIST ALL CURRENT MEDICATIONS
Including eye drops, Vitamins, Birth Control

1. _____ For _____
2. _____ For _____
3. _____ For _____
4. _____ For _____
5. _____ For _____
6. _____ For _____
7. _____ For _____
8. _____ For _____

See Attached List: _____

FAMILY MEDICAL HISTORY

Is there a history of the following please ✔ all that apply:

✔	Disease/Condition	Relationship
	Retinal Detachment	
	High Blood Pressure	
	Diabetes	
	Cancer	
	Heart Disease	
	Thyroid Disease	
	Corneal Problems	
	Blindness	
	Cataracts	
	Glaucoma	
	Crossed Eyes	
	Macular Degeneration	
	Lupus	
	Retinal Problems	

Reviewed by Dr. _____ Date: _____

Additional Comments: _____

_____