Patient Information

Name: ______________________________ Date of Birth: ________________ SSN: ________________ Male ☐ Female ☐

Address: ______________________________________ City: __________________ State: ______ Zip Code: __________

Home number: ___________________ Cell number: __________________ ☐ Okay to leave message ☐ Okay to send text message

E-mail: ____ ☐ Okay to e-mail

Employer/School: ___________________ Occupation/Grade Level: ___________________ Work Number: ________________

Spouse / Guardian: ______________________________________ Phone: ____________________________________

Emergency Contact: ☐ Same as above __________________________ Relationship: ______________ Phone: ______________

Patient Ocular Lifestyle History

Date of Last Eye Exam/Dilation/OptoMap: ____________________________ Doctor/Office: ____________________________

Reason for Today's Visit: ____

Average hours on computer/other electronic devices per day: ________________ Average hours outdoors per week: ________________

Are there any special visual needs for work, home or hobbies? No☐ Yes ☐ If yes please explain: ______________________________

Do you wear glasses? No ☐ Yes ☐ Near ☐ Far ☐ Both ☐ Do you currently wear contact lenses? No☐ Yes ☐ Which Brand? ____________

Patient Ocular History

Eye Operation/Injury/? No☐ Yes ☐ If yes, describe type: ____________________________________ Date: __________________

Do you have any of the following conditions?

☐ Blurred Near/Far/Both	☐ Excessive Tearing	☐ Itchy Eyes	☐ Pink/Red Eyes
☐ Cataracts	☐ Eye Pain/Strain	☐ Lazy Eye/Eye Turn	☐ Retinal Detachment
☐ Double Vision	☐ Floaters or Flashes	☐ Light Sensitivity	☐ Other:
☐ Dry Eyes	☐ Glaucoma	☐ Macular Degeneration	

Family Ocular History *Please mark the appropriate history below and indicate family relation:*

☐ Lazy Eye/Eye Turn: ________________	☐ Macular Degeneration: ________________	☐ Other: ____________
☐ Glaucoma: ______________________	☐ Retinal Detachment: __________________	
☐ Blindness: ______________________	☐ Keratoconus: _______________________	

Ocular Health Check Options

Retinal evaluation is required for all exams, please select one.

☐ OptoMap - Doctor Recommended. No side effects (Often covered with a $39 copay)

☐ Dilation - Side effects include light sensitivity and blurry vision for 6-8 hours

Do you need a contact lens prescription?

☐ Yes - Additional fees up to $175 apply or discounted through your insurance

☐ No

Assignment, Release and Privacy Practice

By signing below, I give City of Vision Eye Care, P.C.'s my permission to file for insurance benefits and collect fees for services and/or materials which have been provided/ordered on my behalf. I understand that I am financially responsible for all charges, whether or not paid by insurance, for services and products rendered on my behalf or my dependents. I understand that any balances not paid by insurance either through incorrect information provided or incorrect billing is my responsibility. I understand that payment is due at the time services and/or materials are rendered

____ ________________

Patient or Responsible Party Signature **Date**

Please Complete Back of Page ➔➔➔➔➔➔

If patient is over 18: *Who do you authorize us to release to/discuss your medical information with:*

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Patient Current Medical Status

Do you use cigarettes/tobaccos? Yes ☐ No ☐ Alcohol? Yes ☐ No ☐ If female, are you currently pregnant? No ☐ Yes ☐ Due Date: __________

Please List All Medications you are taking (including over the counter):

____

____

____

____

____

Are you allergic to any medications No ☐ Yes ☐ If yes, please list: ______________________________

____

Primary Care Physician: ____________________ Office/Number: ______________ Date of Last Visit: ____________

Endocrinologist / Rheumatologist: ______________________________ Office/Number: ____________________

Patient Past Medical History *Please mark the appropriate history below:*

Cardiovascular **None** ☐
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke
- ☐ Vascular / Heart Disease

Hematologic/Lymphatic **None** ☐
- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Leukemia

Respiratory **None** ☐
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea

Constitutional **None** ☐
- ☐ Cancer
- ☐ Headaches
- ☐ Migraines
- ☐ Hearing Problems

Neurological **None** ☐
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder

Skin/Integumentary **None** ☐
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Cancer

Endocrine **None** ☐
- ☐ Diabetes
- ☐ Hormonal Disorders
- ☐ Thyroid Disorders

Psychiatric **None** ☐
- ☐ ADD/ADHD
- ☐ Anxiety/Panic Disorder
- ☐ Autism Spectrum
- ☐ Depression
- ☐ Schizophrenia

Other Conditions:
- ☐ Fibromyalgia
- ☐ Hay Fever
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Other: ______________
- ☐ Other: ______________

Family Health History *Please mark the appropriate history below and indicate family relation:*

Allergic/Immunologic
- ☐ Lupus

Cardiovascular
- ☐ Vascular / Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke

Endocrine
- ☐ Diabetes

Hematologic/Lymphatic
- ☐ Leukemia

Constitutional
- ☐ Cancer
- ☐ Migraines

Neurological
- ☐ Multiple Sclerosis

Other Conditions: