WELCOME TO RENEWED VISION Today's Date _____

PATIENT INFORMATION	PLEASE PRINT

Last _____ MI _____ First _____

Street Address _____

City/State/Zip _____ Email: _____

Phone numbers: Home: _____ Day: _____ Cell: _____

Preferred method of contact (Please check one): _____ Phone _____ Letter _____ Email _____ Secure Messaging

Permission to use Email: Yes No Permission to send Texts: Yes No

Date of Birth: _____ Age: _____ Sex: M F SSN#_____

DEMOGRAPHIC INFORMATION	

Race:
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Hispanic or Latino
___ Native Hawaiian or Other Pacific Islander
___ White
___ Other _____
___ Decline to Specify

Preferred Language:
___ English
___ Spanish
___ French
___ Italian
___ Russian
___ Portuguese

Ethnicity:
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Declined

Employer (or School) _____ Occupation (or Grade) _____

How were you referred to our office?
____ Location/Sign
____ Ad
____ Chamber of Commerce
____ Work
____ Other
____ Insurance
____ School/HeadStart
____ Internet
____ Lion's Club
____ Not Given
____ Doctor Referral: Name of the Clinic/Doctor and phone #: _____

____ Patient Referral: Name of the patient: _____

INSURANCE INFORMATION	Please provide us with all insurance cards

Please note that insurance does NOT cover the Contact Lens Evaluation.

*** For Routine Eye/Wellness exam please provide the following information:*

Vision Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Subscriber Birth Date: _____

Subscriber SSN: _____ Relationship to Patient: _____

***There are times we may need to file your exam or certain procedures to your medical provider. For this reason, please provide your medical insurance. Reasons may include diabetes, cataracts, glaucoma, special testing, pink eye, or eye injuries.*

Medical Insurance: _____ Member ID: _____

Do you have a supplemental/secondary medical insurance? _____

ON THE DAY OF YOUR APPOINTMENT	PLEASE BRING ID AND INSURANCE CARDS

You will be asked to review all information provided for accuracy. This includes information completed online, as well as information gathered while scheduling the appointment.

Medical History Questionnaire

Name_____ Today's Date ____/____/_____ Birth Date: ____/____/_____
Month / Day / Year *Month / Day / Year*

Last Eye Doctor: _____ Last Eye Exam: _____/_____
Month *Year*

Current Medical Dr: _____ Last Medical Exam: _____/_____
Month *Year*

Medical History:

Do you have any allergies to medications? ___ Yes ___ No If yes, explain: _____
_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):
_____
_____

List all major injuries, surgeries and/or hospitalizations you have had: _____
_____

Check any of the following that you have had:

___ Reading Difficulty ___ Retinal Disease ___ Eye Injury

Do you wear glasses? ___ Yes ___ No

Do you wear contact lenses? ___ Yes ___ No If yes, what type of lenses: ___ Rigid ___ Soft ___ Extended Wear ___ Other
What brand do you wear? _____

Have you had refractive surgery? ___ Yes ___ No If yes, what type of surgery? _____

Eye Conditions: Do you currently, or have you ever had any problems in the following areas:

	Yes	No	Unsure		Yes	No	Unsure
Amblyopia (Lazy Eye)	___	___	___	Excessive Tearing	___	___	___
Blepharitis	___	___	___	Eyelid Swelling	___	___	___
Blindness	___	___	___	Eye Pain or Soreness	___	___	___
Cataract(s)	___	___	___	Foreign Body Sensation	___	___	___
Color Blindness	___	___	___	Infection of Eye Lid	___	___	___
Diabetic Retinopathy	___	___	___	Itching	___	___	___
Dry Eye Syndrome	___	___	___	Mucous	___	___	___
Eye Injuries	___	___	___	Ptosis (Drooping Eyelid)	___	___	___
Glaucoma	___	___	___	Redness	___	___	___
Glaucoma Suspect	___	___	___	Sandy or Gritty Feeling	___	___	___
High Risk Medication	___	___	___	Blurred Vision Distance	___	___	___
Macular Degeneration	___	___	___	Blurred Vision Near	___	___	___
Posterior Vitreous Detachment	___	___	___	Distorted Vision	___	___	___
Retinal Detachment	___	___	___	Double Vision	___	___	___
Strabismus (Crossed Eyes)	___	___	___	Flashes of Light	___	___	___
Glare sensitivity	___	___	___	Floaters or Spots	___	___	___
Headaches	___	___	___	Fluctuating Vision	___	___	___
Light Sensitivity	___	___	___	Loss of Central Vision	___	___	___
Tired Eyes	___	___	___	Loss of Side Vision	___	___	___
Burning	___	___	___	Loss of Vision	___	___	___
Dryness	___	___	___				

Other Eye Conditions or Symptoms: _____

**** Please turn this form over and complete Side 2 *****

General Health Conditions: Do you currently, or have you ever had any problems in the following areas:

	Yes	No	Unsure		Yes	No	Unsure
Constitutional (fever, weight loss, etc.)	___	___	___	Skin (rash, itching, skin cancer, etc.)	___	___	___
Ear, Nose, Throat, Mouth	___	___	___	Neurological (multiplesclerosis, etc)	___	___	___
Cardiovascular (heart, hypertension, etc.)	___	___	___	Anxiety or Depression	___	___	___
Respiratory (asthma, emphysema, etc.)	___	___	___	Endocrine (thyroid, diabetes, etc.)	___	___	___
Gastrointestinal	___	___	___	Blood/Lymph (anemia, cholesterol)	___	___	___
Genital, Kidney, Bladder	___	___	___	Allergic/Immunologic (lupus, etc.)	___	___	___
Muscles, Bones, Joints (arthritis, etc.)	___	___	___	Other Symptoms	___	___	___

Are you currently Pregnant or Nursing? Y or N

For any yes answers, please list the specific condition: _____
_____

Please list any other conditions not mentioned above: _____
_____

Family History: Have any of your relatives, living or deceased, had any of these conditions?

Ocular Diseases / Conditions

		Relationship to You
Amblyopia (Lazy eye)	___ Yes ___ No ___ Not Sure	_____
Blindness	___ Yes ___ No ___ Not Sure	_____
Cataract(s)	___ Yes ___ No ___ Not Sure	_____
Color Blindness	___ Yes ___ No ___ Not Sure	_____
Eye Tumors	___ Yes ___ No ___ Not Sure	_____
Glaucoma or Glaucoma Suspect	___ Yes ___ No ___ Not Sure	_____
Macular Degeneration	___ Yes ___ No ___ Not Sure	_____
Retinal Detachment	___ Yes ___ No ___ Not Sure	_____
Strabismus (Eye Turn)	___ Yes ___ No ___ Not Sure	_____

Systemic Diseases / Conditions

Arthritis	___ Yes ___ No ___ Not Sure	_____
Cancer	___ Yes ___ No ___ Not Sure	_____
Diabetes	___ Yes ___ No ___ Not Sure	_____
Heart Disease	___ Yes ___ No ___ Not Sure	_____
High Blood Pressure	___ Yes ___ No ___ Not Sure	_____
Kidney Disease	___ Yes ___ No ___ Not Sure	_____
Lupus	___ Yes ___ No ___ Not Sure	_____
Stroke	___ Yes ___ No ___ Not Sure	_____
Thyroid Disease	___ Yes ___ No ___ Not Sure	_____
Other _____	___ Yes ___ No ___ Not Sure	_____

Social History: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

___ Yes. I would prefer to discuss my Social History information directly with my doctor. (Check appropriate blank)
Do you drive? ___ Yes ___ No If yes, do you have visual difficulty when driving? ___ Yes ___ No If yes, please describe:
_____

Do you drink alcohol? ___ Yes ___ No If yes, type/amount/how long? _____
Do you use tobacco products? ___ Yes ___ No If yes, type/amount/how long? _____
Have you ever smoked in the past? ___ Yes ___ No If yes, what year did you stop smoking? _____
Do you use recreational drugs? ___ Yes ___ No If yes, type/amount/how long? _____
Have you ever been exposed to or infected with: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis ___ No, I have not.