VISION SOURCE
PRESCOTT

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced / Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: ( ) _____

Preferred Language _____ Race: _____ Ethnicity: _____

Communication Preference: ___Telephone ___Postal ___ E-mail Referred by: _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Sometimes Work Only Reading only Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes No

Do you wear contacts? Yes No Type:_____ Solution Used: _____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneration: Yes No When were you diagnosed?_____

What are your visual symptoms: Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

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

Please turn over and complete other side

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PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: **__ None** ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Elevated Cholesterol ___ Other:	**Endocrine:** **___ None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** **___None** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Sleep Apnea ___ Other:
Constitutional: **__ None** ___ Fever/Weight gain/loss ___ Weakness/Fatigue ___ Increase of thirst/urination ___ Other:	**Ocular** **__ None** ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** **__ None** ___ ADHD/ADD ___ Depression ___ Schizophrenia ___ Other:
Neurological: **__ None** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Migraine ___ Other:	**Musculoskeletal:** **__ None** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** **__ None** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: **__ None** ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** **__ None** ___ Crohn's ___ Colitis ___ Acid Reflux ___ Other:	**Ear/Nose/Throat:** **__ None** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: **__ None** ___ Eczema ___ Rosacea ___ Psoriasis ___ Skin Cancer ___ Other	**Allergies** (please list) **__ None** Drug: Environmental: Physical reaction to above:	**Alcohol Use:** **Y N** Amount: **Tobacco Use:** **Y N** **Amount:** **Quit: ____**

Surgeries (type & dates): _____

_____

Please list any medications and/or drugs that you are taking (including herbal) : See Attached List: _____

1 _____	**For** _____	**6** _____	**For** _____
2 _____	**For** _____	**7** _____	**For** _____
3 _____	**For** _____	**8** _____	**For** _____
4 _____	**For** _____	**9** _____	**For** _____
5 _____	**For** _____	**10** _____	**For** _____

FAMILY HISTORY: Has anyone in your family (maternal/paternal grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION

Lupus:	Yes No	_____	Blindness:	Yes No	_____
High Blood Pressure:	Yes No	_____	Cataracts:	Yes No	_____
Diabetes:	Yes No	_____	Glaucoma:	Yes No	_____
Cancer:	Yes No	_____	Crossed Eyes:	Yes No	_____
Heart Disease:	Yes No	_____	Macular Degeneration:	Yes No	_____
Thyroid Disease:	Yes No	_____	Retinal Detachment:	Yes No	_____

Reviewed by:

Dr _____ Date _____

Revised 09/12

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