VISION+
UNION FAMILY OPTOMETRY

Patient's Name: Mr./Mrs./Ms./Dr. _____ Date_____
Male ❑ Female ❑ Date of Birth _____ Social Security # _____
Home Phone _____ Day Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Email Address _____
Whom can we thank for referring you to our office? _____
Vision Service Provider _____
Guarantor's Name _____ Date of Birth _____ Last 4 SS _____
Medical Insurance Company _____
Name of Medical Doctor _____ Phone Number _____

REGARDING INSURANCE: If we are a contract provider for your vision insurance company, we will be happy to bill your insurance for you. If not, it is customary in the vision care profession that the patient is responsible for the entire fee at the time of the exam and the insurance company reimburses the patient. You should attach a copy of your fee slip to your insurance form and send it to your insurance company for reimbursement. If you have any questions, we will be happy to help you. **Payment is due upon time of service.**

PERSONAL HEALTH INFORMATION

Last Eye Exam Date _____ Dilated? YES ❑ NO ❑ Eye Doctor _____
Are you pregnant and/or nursing? ❑ Yes ❑ No

SURGERY:

Disease/Condition	Yes	No	Unsure	Please explain
Ocular Surgery	❑	❑	❑	_____
Systemic Surgery	❑	❑	❑	_____
Other Surgery	❑	❑	❑	_____

SYSTEMS REVIEW: Do you currently, or have you in the past had any problems in the following:

	Yes	No	Unsure
Eye			
Visual Field Loss	❑	❑	❑
Flashes/Floaters	❑	❑	❑
Double Vision	❑	❑	❑
Dry Eyes	❑	❑	❑
Ocular Burn	❑	❑	❑
Ocular Allergies	❑	❑	❑
Cardiovascular/Vascular			
Heart Disease	❑	❑	❑
High Cholesterol	❑	❑	❑
High Blood Pressure	❑	❑	❑
Endocrine			
Diabetes (Type ___)	❑	❑	❑
Gout	❑	❑	❑
Crohn's Disease	❑	❑	❑
Thyroid Problems	❑	❑	❑
Renal/Kidney Problems	❑	❑	❑
Pituitary Problems	❑	❑	❑
Gastrointestinal			
IBD/IBS	❑	❑	❑
Gastrointestinal Disorder	❑	❑	❑
Immunological			
AIDS/HIV	❑	❑	❑
Herpes Simplex/Zoster	❑	❑	❑
Lyme Disease	❑	❑	❑
Tuberculosis/TB	❑	❑	❑
Sarcoidosis	❑	❑	❑
Sjogren's	❑	❑	❑
Syphilis	❑	❑	❑

	Yes	No	Unsure
Dermatological/Skin			
Ocular Rosacea	❑	❑	❑
Psoriasis	❑	❑	❑
Skin Cancer	❑	❑	❑
Ears, Nose, Mouth, Throat			
Sinus Congestion/Disease	❑	❑	❑
Dry Mouth/Throat	❑	❑	❑
Chronic Cough	❑	❑	❑
Hematologic/Lymphatic			
Blood Disorder	❑	❑	❑
Anemia	❑	❑	❑
Vascular Problems	❑	❑	❑
Musculoskeletal			
Ankylosing Spondylitis	❑	❑	❑
Arthritis	❑	❑	❑
Downs syndrome	❑	❑	❑
Marfan's Syndrome	❑	❑	❑
Muscular Dystrophy	❑	❑	❑
Myasthenia Gravis	❑	❑	❑
Neurological			
Headaches/Migraines	❑	❑	❑
Seizures	❑	❑	❑
Psychiatric			
Alzheimer's	❑	❑	❑
Anxiety Disorder	❑	❑	❑
Autism	❑	❑	❑
Brain Trauma	❑	❑	❑
Depression	❑	❑	❑
Respiratory			
Asthma	❑	❑	❑
Emphysema	❑	❑	❑
Bronchitis	❑	❑	❑

IF you answered YES to any of the conditions listed or have a condition not listed, please list and explain **medications**:

_____

_____

List any **additional medications** you are currently taking (including vitamins, asprin, oral contraceptives, over the counter medications or eye drops)_____

_____

_____

Do you have any known **drug/medication allergies**?_____

Do you have any other **allergies**:_____

FAMILY HISTORY:

Please notate any family history of the following including parents, grandparents, siblings, children, living and/or deceased in the following:

Ocular Disease/Condition	Yes	No	Unsure	Relationship To You
Blindness	❑	❑	❑	_____
Cataracts	❑	❑	❑	_____
Crossed Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____

Systemic Disease/Condition	Yes	No	Unsure	Relationship To You
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____

Other:_____

Do you drink alcohol? ❑ Yes ❑ No If yes, ❑ Mild ❑ Moderate ❑ Severe Drinks per week _____

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/for how long _____

Do you use illegal drugs? ❑ Yes ❑ No

Have you ever been exposed and/or infected with: Syphillis, HIV, Hepatitis, Gonorrhea? ❑ Yes ❑ No

SPECTACLE/CONTACT LENS INFORMATION

Do you wear glasses? ❑ Yes ❑ No If yes, which lens design ❑ Progressive ❑ Bifocal ❑ Single Vision ❑ Not Sure

Do you wear contact lenses? ❑ Yes ❑ No If yes, which lens design ❑ Single Vision ❑ Multifocals ❑ Monovision

Type of contact lenses ❑ Soft ❑ Hard (RGP) ❑ Other: _____

Brand of Contacts: _____ Base Curve _____ Diameter _____

Previous Contact Lens Prescription: Right Eye _____ Left Eye _____

Average wear time per day: _____ hours/day

How often do you replace your contacts? _____

Disinfecting solution _____

Eye drops _____

Patient's Signature: _____ Date: _____

If patient is under the age of 18 years old, parent signature is required.