FAMILY VISION CARE

New Patient Questionnaire

PERSONAL INFORMATION

PATIENTS NAME: _____ REFERRED BY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

DATE OF BIRTH: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ SOCIAL SECURITY #: _____

LAST EYE EXAM: _____ IF MARRIED, NAME OF SPOUSE: _____

PHYSICIAN INFORMATION

NAME OF MEDICAL DOCTOR: _____

DOCTOR'S PHONE #: _____

LAST MEDICAL EXAM: _____

INSURANCE PROVIDER INFORMATION

PRIMARY INSURANCE PROVIDER: _____

SECONDARY INSURANCE PROVIDER: _____

RESPONSIBLE PARTY: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ BIRTH DATE: _____

OFFICE PHONE #: _____

MEDICAL HISTORY

HAVE YOU EXPERIENCED ANY ALLERGIC REACTIONS TO MEDICATIONS? ☐ YES ☐ NO

IF YES, LIST THEM: _____

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING: _____

LIST ANY MAJOR INJURIES, SURGERIES AND/OR HOSPITALIZATIONS: _____

CHECK THE BOX IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

☐ CATARACTS	☐ EYE INFECTIONS	☐ LAZY EYE	☐ DRY EYES
☐ DOUBLE VISION	☐ EYE INJURY	☐ BULGING EYES	☐ FLASHES
☐ DROOPING EYELID	☐ GLAUCOMA	☐ RED EYES	☐ FLOATERS

DO YOU WEAR GLASSES? ☐ YES ☐ NO

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

ARE YOU PREGNANT AND/OR NURSING? ☐ YES ☐ NO

DO YOU PLAN ON BUYING GLASSES TODAY? ☐ YES ☐ NO

DO YOU PLAN ON BUYING CONTACTS? ☐ YES ☐ NO

DO YOU OWN POLARIZED SUNGLASSES? ☐ YES ☐ NO

DISCLAIMER

I UNDERSTAND THAT FEES FOR PROFESSIONAL SERVICES ARE DUE AND PAYABLE WHEN SERVICES ARE RENDERED. ANY EXCEPTIONS WILL BE MADE ONLY BY SPECIFIC ARRANGEMENTS BEFORE SERVICES ARE RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR THIS ACCOUNT REGARDLESS OF INSURANCE COMPANY ACTION.

I AGREE TO PAY A MONTHLY FINANCE CHARGE OR 1.5% PER MONTH (ANNUAL PERCENTAGE OF 18%) TO BE APPLIED TO ANY AMOUNT NOT PAID AFTER 30 DAYS. I UNDERSTAND THAT THERE IS A $15.00 RETURNED CHECK CHARGE. I AGREE TO PAY ALL COSTS AND EXPENSES OF COLLECTION (40%) INCLUDING A REASONABLE ATTORNEY'S FEE, IF NECESSARY, TO COLLECT ANY DEBT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO ALL INSURANCE COMPANIES AND OTHER PROVIDERS, AS NECESSARY. I ALSO UNDERSTAND THAT HAVING MY EYES DILATED MAY IMPAIR MY ABILITY TO DRIVE. I TAKE FULL RESPONSIBILITY FOR MY ACTIONS WHILE DRIVING WITH DILATED EYES.

SIGNATURE: _____ DATE: _____

FAMILY HISTORY

PLEASE RECORD ANY FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN; LIVING OR DECEASED)

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
BLINDNESS	☐	☐	☐	
CATARACT	☐	☐	☐	
DOUBLE VISION	☐	☐	☐	
GLAUCOMA	☐	☐	☐	
MACULAR DEGENERATION	☐	☐	☐	
RETINAL DETACHMENT	☐	☐	☐	
ARTHRITIS	☐	☐	☐	
CANCER	☐	☐	☐	
DIABETES	☐	☐	☐	
HEART DISEASE	☐	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	☐	
KIDNEY PROBLEMS	☐	☐	☐	
LUPUS	☐	☐	☐	
THYROID PROBLEMS	☐	☐	☐	
OTHER	☐	☐	☐	

SOCIAL HISTORY

THIS CAN BE DISCUSSED PERSONALLY WITH THE DOCTOR IF PREFERRED. WE KEEP ALL INFORMATION CONFIDENTIAL

	YES	NO	
DO YOU DRIVE?	☐	☐	
DO YOU HAVE VISUAL DIFFICULTY WHILE DRIVING?	☐	☐	IF YES, PLEASE DESCRIBE: _____
DO YOU USE TOBACCO PRODUCTS?	☐	☐	IF YES, TYPE/HOW LONG: _____
DO YOU DRINK ALCOHOL?	☐	☐	IF YES, FREQUENCY/HOW LONG: _____
DO YOU USE ILLEGAL DRUGS?	☐	☐	IF YES, FREQUENCY/HOW LONG: _____
HAVE YOU EVER BEEN INFECTED WITH AN STD?	☐	☐	IF YES, WHICH ONE?: _____

REVIEW OF SYSTEMS

DO YOU CURRENTLY, OR HAVE EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS?

DISEASE/SYSTEM	YES	NO
CONSTITUTIONAL		
EXCESSIVE WEIGHT LOSS/GAIN	☐	☐
NEUROLOGICAL		
HEADACHES	☐	☐
MIGRAINES	☐	☐
SEIZURES	☐	☐
EYES		
LOSS OF VISION	☐	☐
BLURRED VISION	☐	☐
DISTORTED VISION/HALOS	☐	☐
LOSS OF SIDE VISION	☐	☐
DOUBLE VISION	☐	☐
DRYNESS	☐	☐
MUCOUS DISCHARGE	☐	☐
REDNESS	☐	☐
SANDY OR GRITTY FEELING	☐	☐
ITCHING OR BURNING	☐	☐
FOREIGN BODY SENSATION	☐	☐
EXCESSIVE TEARS/WATERING	☐	☐

DISEASE/SYSTEM	YES	NO
GLARE/LIGHT SENSITIVITY	☐	☐
EYE PAIN OR SORENESS	☐	☐
CHRONIC INFECTION OF EYE	☐	☐
STIES OR CHALAZION	☐	☐
FLASHES/FLOATERS IN VISION	☐	☐
TIRED EYES	☐	☐
EARS, NOSE, THROAT		
ALLERGIES/HAY FEVER	☐	☐
SINUS CONGESTION	☐	☐
RUNNY NOSE	☐	☐
POST-NASAL DRIP	☐	☐
CHRONIC COUGH	☐	☐
DRY THROAT/MOUTH	☐	☐
RESPIRATORY		
ASTHMA	☐	☐
CHRONIC BRONCHITIS	☐	☐
EMPHYSEMA	☐	☐
ENDOCRINE/THYROID	☐	☐
INTEGUMENTARY (SKIN)	☐	☐

DISEASE/SYSTEM	YES	NO
VASCULAR		
DIABETES	☐	☐
HEART PAIN	☐	☐
HIGH BLOOD PRESSURE	☐	☐
VASCULAR DISEASE	☐	☐
GASTROINTESTINAL		
DIARRHEA	☐	☐
CONSTIPATION	☐	☐
GENITOURINARY		
GENITALS/KIDNEY/BLADDER	☐	☐
BONES/JOINTS/MUSCLES	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
MUSCLE PAIN	☐	☐
JOINT PAIN	☐	☐
LYMPHATIC		
ANEMIA	☐	☐
BLEEDING PROBLEMS	☐	☐
IMMUNOLOGIC		
PSYCHIATRIC	☐	☐

MISSION STATEMENT

"WE IMPROVE YOUR QUALITY OF LIFE BY PROVIDING THE FINEST IN VISION CARE FOR PEOPLE OF ALL AGES IN NORTHERN UTAH"