EyeWish Optometry

"You will see the difference"

Welcome to our office! Please fill out the following. Your responses will be treated as confidential medical information.

Name (Last, First, M.I.) _____

Nickname _____ **Gender**_____

DOB (MM/DD/YY) _____ **Age** _____

Home address _____

City _____ **State** _____ **Zip** _____

Home phone (_____ **)** _____

Work phone (_____ **)** _____

Cell phone (_____ **)** _____

Email address _____

How do you prefer to be contacted?

□ Home □ Work □ Cell □ Email

Height_____ inches **Weight**_____ lbs.

Race_____ **Ethnicity**_____

Preferred Language_____

Employer_____ **Occupation**_____

Hobbies _____

How did you learn about our office? _____

Vision Insurance (check one):

Name of insured : _____

□ None □ MES □ VSP

□ Blue View Vision □ Medicare □ Other

Insured's DOB ____/_____/_____ SSN __ __ __ -__ __ -__ __ __

Relationship to insured**:**

□ Self □ Spouse/Partner □ Child □ Other

Medical Insurance _____

□ PPO □ HMO

Name of insured (Last, First) _____

ID # _____

Emergency Contact:

Name_____

Phone (____) _____

Relationship to patient _____

Eye and Medical History

What is the reason(s) for your visit here today?

_____

Last Eye Exam (Date, Doctor) _____

Do you currently wear glasses? □ Yes □ No

Would you like thinner or lighter eyewear? □ Yes □ No

Would you rather not wear glasses? □ Yes □ No

Do you have sunglasses that filter 100% UVA & UVB rays?

□ Yes □ No □ Not Sure

Are you bothered by glare or reflection, particularly when driving at night? □ Yes □ No

Do you wear contact lenses? □ Yes □ No

If yes, which type? (Check one) □ Soft □ Hard Gas Perm.

Other_____

Lens Brand/Powers _____

Average hours worn/day _____

Cleaning/disinfection solution(s)_____

How often do you sleep in your lenses?_____

At what age did you first start wearing contacts?_____

Do you experience any of the following eye symptoms?

(Check all that apply)

Burning	□ Itching	□ Tearing/watering	□ Pain
Eyestrain	□ Floaters	□ Headaches	□ Glare
Blurry Vision	□ Light flashes	□ Light Sensitivity	□ Double vision

□ Irritation/Foreign body sensation

Have you ever had any eye injuries or surgeries to your eyes?

□ Yes □ No

If yes, please list and indicate which eye(s) and the approximate date(s).

_____

_____

Who/where is your primary care doctor or internist?

_____

When was your last physical exam with your primary care doctor? _____

Are you being followed by a doctor for any medical condition(s)?
□ Yes □ No If yes, please list

_____

_____

Are you pregnant or nursing? □ Yes □ No

Do you use a computer? □ Yes □ No

How many hours (average) per day? _____

Do <u>you</u> or any of <u>your relatives</u> have any of the following?

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□ Glaucoma? Who? _____
□ Cataracts? Who? _____
□ Macular Degeneration? Who? _____
□ Eye Injury? Who? _____
□ Retinal Disease / Detachment? Who? _____
□ Blindness? Who?_____
□ Strabismus (eye turn)? Who? _____
□ Diabetes? Who? _____
□ Dry Eye? Who? _____
□ Cancer? Who? _____
□ Heart Disease? Who? _____
□ Hypertension? Who? _____
□ High Cholesterol? Who? _____
□ Kidney Disease? Who? _____
□ Stroke? Who? _____
□ Thyroid Condition? Who? _____
□ Other? Who? _____

Do you wake up with a headache? □ Yes □ No
Do you find it necessary to nap during the day? □ Yes □ No
Do you snore? □ Yes □ No
Is your vision blurred in the morning? □ Yes □ No

Do you smoke? □ Current □ Former □ Never
Do you drink alcohol? □ Socially □ Yes □ No

Please list all of the medications including eyedrops you are currently taking, both prescription and over the counter:

_____
_____
_____

Do you have any allergies to medications? □ Yes □ No
If yes, please list

_____
_____
_____

Have you ever had an allergic reaction to drops used in an eye exam? □ Yes, _____ □ No

Do you have seasonal allergies/hay fever? □ Yes □ No
Do you have any other allergies? □ Yes □ No
If yes, please list here:_____
_____
_____

Please initial and date at every visit:
Date_____ Date_____ Date_____
Date_____ Date_____ Date_____
Date_____ Date_____ Date_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that **EyeWish Optometry** make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that **(PLEASE CHECK ONLY ONE):**

- ❑ I have read or had explained to me **EyeWish Optometry's** Notice of Privacy Practice and agree to continue my care with **EyeWish Optometry** under said terms.
- ❑ I was given the opportunity to read **EyeWish Optometry's** Notice of Privacy Practices and declined but wish to continue my care with **EyeWish Optometry** under the terms of **EyeWish Optometry's** privacy policies.
- ❑ I have read or had explained to me **EyeWish Optometry's** Notice of Privacy Practice and do not wish to continue my care with **EyeWish Optometry** under said terms.
- ❑ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as:

_____

- ❑ I **DO** authorize EyeWish Optometry to release my medical diagnoses to my vision plan
- ❑ I **DO NOT** authorize EyeWish Optometry to release my medical diagnoses to my vision plan

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient_____ Date_____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative_____ Relationship to Patient_____