Village Eye Care, Inc.

Patient Registration:

Last:_____First:_____MI_____
Address:_____
_____
Tel:(___)_____Email:_____
Date of Birth:_____Age:_____Sex: M/F
Purpose of visit:_____
_____

Vision Insurance Information:

Vision Insurance(Circle): VSP/ EyeMed/ Other

Medical Insurance Information

Medical Insurance:_____PPO/HMO/IPA
Member ID:_____Group ID:_____
Policy Holder's Name(Last,First):_____
Policy Holder DOB:___/___/____ SSN:_____
Relationship to Patient:_____

Who can we thank for your referral to our office?

_____

Medical History:

Have you ever been diagnosed or treated for any of the following health problems?(circle yes, no and f for family history)

Allergies	_____y/n/f
Arthritis	_____y/n/f
Blood/Lymph	_____y/n/f
Cancer	_____y/n/f
Cholesterol	_____y/n/f
Diabetes	_____y/n/f
Digestive/Gastric	_____y/n/f
Ears/Nose/Throat	_____y/n/f
Endocrine	_____y/n/f
Fatigue	_____y/n/f
Fevers	_____y/n/f
Heart Disease	_____y/n/f
High Blood Pressure	_____y/n/f
Immune	_____y/n/f
Integumentary (Skin disease)	_____y/n/f
Kidney	_____y/n/f
Muscle Bone	_____y/n/f
Neurological/Headaches	_____y/n/f
Psychological	_____y/n/f
Respiratory	_____y/n/f
Sinus	_____y/n/f
Stroke/Seizures	_____y/n/f
Throat Infections	_____y/n/f
Thyroid	_____y/n/f
Unusual Weight Loss/Gains	_____y/n/f

Current Medications: _____
_____
_____

Allergies: _____

Surgical Hx:
List any prior surgeries:_____

Social History:
Do you use cigarettes/alcohol? Y/N Freq:_____

Ocular History:

Date of Last Eye Exam:_____

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infections
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Other Eye Disorders _____
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Night vision hard

Family Ocular History:

Is there a family medical history of the following:

Blindness	_____y/n
Cataracts	_____y/n
Corneal Problems	_____y/n
Diabetes	_____y/n
Glaucoma	_____y/n
Heart Disease	_____y/n
Lazy Eye	_____y/n
Macular Degeneration	_____y/n
Retinal Problems	_____y/n

Visual Needs Assessment:

Hours of computer usage:_____
Hours of outdoor activity:_____
Hobbies:_____
Eyestrain/neck strain/headaches:_____
Sports:_____
Hours before reading fatigue?_____