Patient information:

First Name	Last Name
Date of Birth	
Primary Phone Number	Cell, Home, or Work?
Email	
Street Address	
City/State/Zip Code	
Employer/Occupation	
Last Four of Social Security Number	

New Patients:

How did you learn about our clinic

If patient is under 18:

Parent/Guardian Name	Phone Number

HIPAA Privacy Act

I acknowledge that I have read and/or received a copy of the Notice of Privacy Policy of Valley Eye Clinic. I understand that the doctor may use and disclose personal health information to provide me with vision care services and treatment, process my vision and medical insurance claims, and to communicate with me as provided in the Notice of Privacy Practices.

I understand and agree that health/vision/accident insurance policies are an arrangement between an insurance carrier and myself. I understand fees for professional services rendered to me will be immediately due and payable on the date of service. Protected health information (PHI) may be disclosed or used for treatment, payment, or health care operations. I understand my medical insurance may be used in cases if there is a medical diagnosis. I hereby authorize my optometrist/medical records to be released and transferred when medically necessary.

Signature of Patient or Authorized Representative:_____

Date:_____

Patient Name:_____

Primary Care Physician First and Last Name:_____

Medications:_____

_____

Allergies (medical or seasonal):_____

Medical History (circle all that apply)

General Health
Fever/Fatigue Pregnancy

Cardiovascular
High Blood Pressure Stroke Heart Disease

Respiratory
Asthma COPD Bronchitis

Genitourinary
Kidney Problems Other_____

Dermatologic
Rosacea Eczema Psoriasis

Neurological
MS Headache/Migraine

Psychiatric
Depression Anxiety

Endocrine
Diabetes Thyroid

Musculoskeletal
Arthritis Other_____

Gastrointestinal
Crohn's Disease IBS

Hematological/Lymphatic
Anemia Bleeding Disorders

Other:
_____

Family History (circle all that apply)

High Blood Pressure Diabetes Cholesterol Thyroid Heart Disease Cancer Other_____

Ocular Symptoms (circle all that apply)

Blurred Vision Double Vision Floaters/Flashes Halos Glare Mucous Discharge

Ocular History (circle all that apply for family or self)

Glaucoma: Family Self **Retinal Disease:** Family Self **Blindness:** Family Self
Cataracts: Family Self **Crossed/Lazy Eye:** Family Self **Macular Degeneration:** Family Self
List any Ocular Surgeries:_____ **List any Ocular Injuries:**_____

1. Do you currently wear glasses? YES NO

2. What glasses do you own? Single Vision Bifocals Trifocals Progressive Lens Sunglasses

3. Circle all that apply: I don't want to wear glasses Problems with glare Problems with night vision

4. Do you currently wear contacts? YES NO

If answer is no, would you be interested in trying contacts? YES NO

5. Lifestyle/Hobbies (circle those that apply to you and/or list any we do not have listed):
Running Biking Gaming Needle Point Shooting/Archery Reading Fishing Athletics

Other:_____

Dry Eye Questions:

Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0 (never)	1 (sometimes)	2 (often)	3 (constant)
Dryness, Grittiness or Scratchiness	0	1	2	3
Soreness or irritation	0	1	2	3
Burning, watering or redness	0	1	2	3
Eye fatigue	0	1	2	3

Skin Care Use

Do you wear:			If yes, what brand?				
Mascara	YES	NO	_____	Eye Shadow	YES	NO	_____
Eyeliner	YES	NO	_____	Moisturizer	YES	NO	_____
				Make-up Remover	YES	NO	_____

FOR PATIENT USE

FOR OFFICE USE

PT INITIALS / ID: _____

DATE: _____

Lifestyle Index

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc.** Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 ○ ○ ● ○ ○

Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Number of hours per day using a digital device: _____

Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Light Sensitivity

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Dizziness

You experience dizziness, motion sickness, or vertigo.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Additional Notes

Any additional notes you'd like to add: _____

_____