Patient information:

First Name	Last Name	
Date of Birth	Last Four of Social Security #	
Cell Phone #	Home Phone #	Preferred contact method
Address Line 1:		
Address Line 2: (apt or unit #)	Email	
City/State/Zip Code		
Employer/Occupation		
Parent/Guardian (if under 18)		
Individuals allowed access to medical file (example: parent or guardian, *if under 18,* or court appointed conservator):	Phone #	
New Patients - how did you hear about our clinic?		

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	_____

Ocular Surface Health Questions

Please check all symptoms experience since last visit

☐Dry Eyes
☐Blurry Vision
☐Redness
☐Burning
☐Itching
☐Light Sensitivity
☐Excessive tearing/watery eyes
☐Tired eyes/eye fatigue
☐Stringy mucous in or around the eyes
☐Foreign Body Sensation/Gritty
Scratchy, feeling of sand or grit in eye

Have you used eye drops in the last 2 hours?
Yes ☐ No ☐

Does your vision change throughout the day?
Yes ☐ No ☐

Can you wear your contacts comfortably as long as you'd like?
Yes ☐ No ☐

Rosacea

Does your face flush easily, eating spicy foods, alcohol, or hot showers?

Yes ☐ **No** ☐

Do you have bloating with certain foods?

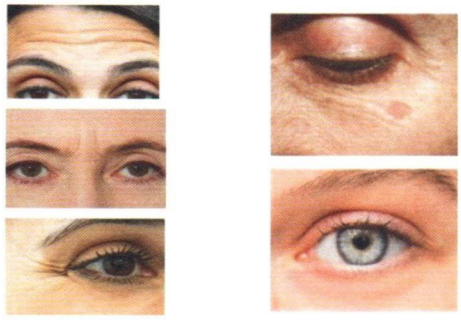
Yes ☐ **No** ☐

If so, which ones?

External Exam

Would you like your eyes to be more open?

Yes ☐ **No** ☐



Are there any areas around your eyes that you wish could be changed such as wrinkles, dark spots or texture? Do people comment that you look tired or angry, etc?

Yes ☐ **No** ☐

Lifestyle Index

PT INITIALS / ID _____

DATE _____

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
of any severity each week, usually getting worse later in the day

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

Stiffness / pain in neck / shoulders
when you work at a computer or read

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

Discomfort with Computer Use
in your eyes (redness, burning) after long hours looking at the screen

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

Tired Eyes
with increasing feeling of eye fatigue throughout the day

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

Dry Eye Sensation
feeling progressively more gritty/sandy while working at computer or reading

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

Light Sensitivity
especially with brighter, stronger lights like fluorescents or headlights

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

Dizziness
or an experience like motion sickness or vertigo

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

FOR OFFICE USE

Neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	

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