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): Name(s):	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_____

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
Dermatologic
Rosacea Eczema Psoriasis
Neurological
MS Headache/Migraine
Psychiatric
Depression Anxiety
Endocrine
Diabetes Thyroid
Musculoskeletal
Arthritis Other_____
Gastrointestinal
Crohn's Disease IBS
Hematologic/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 **Crossed/Lazy Eye:** Family Self
Cataracts: Family Self **Blindness:** 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 NO, are you 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 Embroidery/X Stitch Shooting/Archery Reading Fishing Athletics

Other:_____

Skin Care Use Do you wear any of the following: If YES, what brand?

Eyeliner	YES	NO	_____	Moisturizer	YES	NO	_____
Mascara	YES	NO	_____	Make-up Remover	YES	NO	_____
Eye Shadow	YES	NO	_____				

YES or NO I would like my eyeglass and/or contact lens prescription sent to me electronically via Valley Eye Clinic's patient portal.

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Signature: _____Date:_____

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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