****

**Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to review / complete the following information to ensure that it is current and accurate. If you have any questions, please do not hesitate to ask.**

**Title:**

**First Name:**

**MI:**

**Last Name:**

**Preferred Name:**

**Patient’s Sex:**

**Date of Birth:**

**SSN:**

**Preferred Language:**

**Race:** **☐** Black **☐** Asian **☐** White **☐** Native **☐** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **☐** Decline

**Ethnicity: ☐** Hispanic/Latino

 **☐** Not Hispanic/Latino

 **☐** Other\_\_\_\_\_\_\_\_\_\_\_ ☐Decline

**Address:**

**City:**

**State:**

**Zip Code:**

**Cell Phone:**

**Work Phone:**

**Home Phone:**

**Emergency Contact Name:**

**Phone:**

**Email Address:**

**Employer/Occupation:**

**Guardian or Person Responsible for Account:**

**Have you had the Flu Shot this year?**

 ☐ **Yes** ☐ **No**

Height:\_\_\_\_\_’\_\_\_\_\_\_” ☐ Decline

Weight: \_\_\_\_\_\_\_\_LBS ☐ Decline

**PRIMARY INSURANCE INFORMATION**

**Name of Primary Insurance:**

**Insured’s Full Name:**

**Primary Insured’s ID Number:**

**Group Number:**

**Primary Insured’s Sex:**

**Patient’s Marital Status:**

**Patient’s Relationship to Insured:**

**Primary Insured’s Occupation:**

**Primary Insured’s Date of Birth:**

**SECONDARY INSURANCE INFORMATION**

**Name of Secondary or Medical Insurance:**

**Insured’s Full Name:**

**Insured’s ID Number:**

**Group Number:**

**Secondary Insured’s Sex:**

**Patient Relationship to Insured:**

**Secondary Insured’s Occupation:**

**Secondary Insured’s Date of Birth:**

Please note that Mount Vernon Vision Source will bill the above insurance and the information is accurate for our billing office. ***Please initial***

**PATIENT HISTORY AND INFORMATION**

**What is the main reason for today’s exam?**

**SPECTACLE HISTORY**

**I currently wear glasses: ☐ Full-time: ☐ Part-Time:**

**CONTACT LENS HISTORY**

**I currently wear contacts: ☐ Full-time: ☐ Part-time: Current Brand:**

**List all Eye Drops you use (OTC and RX):**

**How often used ☐ DAILY ☐OCCASIONALLY ☐ RARELY**

**Mark boxes to those that apply. Boxes left unmarked will be considered a NO**

**EYE HISTORY**

|  |  |  |
| --- | --- | --- |
| **☐ Blindness:**  | **☐ Headaches** | **☐ Itching:**  |
| **☐ Eye Turn (Strabismus):**  | **☐ Blurred Vision**  | **☐ Burning** |
| **☐ Lazy Eye:**  | **☐ Double Vision:**  | **☐ Excess Tearing/Watering** |
| **☐ Keratoconus** | **☐ Eyes hurt or tired** | **☐ Dryness**  |
| **☐ Glaucoma:**  | **☐ Halos around lights:**  | **☐ Feel sand/gritty**  |
| **☐ Cataracts:**  | **☐ Bothered by light/sun:**  | **☐ Flashing Lights**  |
| **☐ Macular Degeneration:**  | **☐ Frequent styes** | **☐ Floaters or Spots**  |
| **☐ Retinal Detachment**  | **☐ Eyes frequently red:**  |  |

|  |  |
| --- | --- |
| **Eye Injuries** | **Eye Surgeries** |
| **How many hours a day do you use a computer?** | **Describe any visual symptoms from computer use:** |

**PRIMARY CARE PHYSICIAN**

**Clinic Name:**

**Primary Care Physician:**

**Date of Last Visit:**

**Current Medications:**

**☐ Not taking any medications**

 **Medicine Allergies:**

**☐ No known allergies to medications**

**Y N N/A**

**Pregnant or Nursing**:

**GENERAL HEALTH CONDITION**

|  |  |  |
| --- | --- | --- |
| **☐ Migraines**  |  **☐ Arthritis:**  | **☐ Cardiovascular (high blood pressure, etc.):**  |
| **☐ Multiple Sclerosis:**  | **☐ Allergies/Hay Fever** | **☐ Stroke** |
| **☐ Diabetes** | **☐ Asthma:**  | **☐ Anemia:**  |
| **☐ Thyroid** | **☐ Emphysema:**  | **☐ Cancer:** |

**FAMILY HISTORY (include only grandparents, parents, and siblings)**

|  |  |
| --- | --- |
| **☐ Poor Vision:** | **☐ Cancer** |
| **☐ Blindness:**  | **☐ Diabetes:**  |
| **☐ Eye Turn:**  | **☐ High Blood Pressure:**  |
| **☐ Lazy Eye:**  | **☐ Stroke:**  |
| **☐ Glaucoma:**  | **☐ Thyroid Disease** |
| **☐ Cataracts:**  | **☐ Other Inherited Disease:**  |
| **☐ Macular Degeneration:**  | **If other, what Disease?** |
| **☐ Retinal Detachment:**  |  |

**SOCIAL HISTORY**

**How often do you consume alcohol? ☐ NEVER ☐ OCCASIONALY ☐ DAILY**

**Do you have? ☐ Hepatitis: ☐ HIV: ☐ STDs:**

**How often do you smoke/use tobacco products?**

**☐ CURRENT EVERY DAY SMOKER**

**☐ CURRENT OCCASIONAL SMOKER**

**☐ FORMER SMOKER**

**☐ NEVER SMOKER**

**☐ DECLINE TO ANSWER**