Welcome to Superior Vision

Patient Information Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____

Patients Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Age: _____ Birth Date: _____Sex: Male:_____Female:____

Marital Status: Single: ____ Married: ____ Divorced: ____ Widowed: ____ Other:_____

Race: _____ Occupation: _____ Email: _____

Would you like to receive TEXT message confirmations? Yes: ____ No: ____

How did you hear about us? _____

What is the name and number of your Primary Care Physician? _____

Guardian: _____

Primary Insurance: Please Circle (Vision or Medical)

Subscriber's Name: _____ SSN: _____DOB: _____

Relationship to Patient: _____ Phone #: _____

Address (if different from patient): _____

City/State/Zip: _____

Pharmacy Information

Pharmacy Name, Address, Phone Number: _____

Questions

- What's the main reason for your visit today? Exam: _____ Glasses: _____ Contacts: _____
- Have you worn? Eyeglasses _____ Contacts _____
- When was your last eye exam? _____
- Do you smoke? Yes: ____ No: _____ How long? _____ How many packs a day? _____
- Do you have Seasonal Allergies? Yes: _____ No: _____

EYE AND GENERAL HEALTH HISTORY

Please check yes or no and circle if there is more than one

Yes	No		Yes	No	
( )	( )	Asthma, Bronchitis, Emphysema	( )	( )	Sickle Cell Anemia
( )	( )	Kidney Disease	( )	( )	Head or Spinal Injuries
( )	( )	Tuberculosis	( )	( )	Seizures, Convulsions, Fainting
( )	( )	Diabetes…. Year of Diagnosis _____	( )	( )	Stroke
( )	( )	Insulin….. if yes # of years ____	( )	( )	Permanent Defect from Illness, Disease, or Injury
( )	( )	Migraines	( )	( )	(Women) Are you pregnant?
( )	( )	Psychiatric Disorder	( )	( )	High Blood Pressure
( )	( )	Any Nervous Disorder	( )	( )	HIV/AIDS
( )	( )	Heart Attack or Heart Failure	( )	( )	Other Diagnosed Health Problems _____
( )	( )	Hyperthyroidism			
( )	( )	Hypothyroidism	( )	( )	Rheumatoid Arthritis
( )	( )	Congestive Heart Failure	( )	( )	Cancer (List Type):_____
( )	( )	Ulcer, Heartburn			

Please check all Surgeries you have had:

Tonsillectomy____ Heart By-Pass___ Hysterectomy ___ C-Section ____ Stint ___ Gall Bladder____ Knee ____ Hip _____

Mastectomy _____ Appendectomy _____ Back ____ Transplant ____ Dental Surgery _____

Other: Please List _____

Dates of Surgery: _____

Please List all Medications Currently Taking: **Please List Medications you are ALLERGIC to:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Ocular History (Have you been diagnosed with any of the following in the past?)

Yes	No		Yes	No		Yes	No	
( )	( )	Cataracts	( )	( )	Crossed Eyes	( )	( )	Cornea Disease(front surface of Eye)
( )	( )	Retina Disease	( )	( )	Iritis (red inflamed eye)	( )	( )	Injury_____
( )	( )	Glaucoma	( )	( )	Other Eye Disorder: _____			

Cataracts (Date of Surgery): Right _____ Left _____

Retina Surgery (Date of Surgery): Right _____ Left _____

Eye Surgeries: Cataracts_____ Lasik _____ Other_____

Family History (Blood Relatives Only: Mark Relation, i.e. Mother, Father, Grandparent, Aunt)

Yes	No		Yes	No	
( )	( )	Glaucoma _____	( )	( )	Diabetes IDDM/Type II _____
( )	( )	Cataracts _____	( )	( )	Heart Attack _____
( )	( )	Cornea Disease _____	( )	( )	Diabetic Retinopathy _____
( )	( )	Macular Degeneration _____	( )	( )	Retinal Detachment _____
( )	( )	Retinitis Pigmentosa _____	( )	( )	Stroke _____
( )	( )	Blindness _____	( )	( )	High Blood Pressure_____
( )	( )	Cancer _____			

( ) ( ) Other General Medical Problems: _____