

Welcome to Glaser Vision Optometry

Date _____

Please PRINT clearly

Patients last name:	First name:	Social Security #:	Date of Birth:
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Address:	City/State/Zip:
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Financially responsible/Primary Insurance holder:	Spouse's Name:	Children's Names and ages:
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Social Security # of Primary Insurance Holder:	Place of Employment of Primary Insurance Holder:
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Home Phone:	Work Phone:	Pager/Cell/E-mail (optional):
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How did you learn about our office and whom may we thank?

What activities do you enjoy?

- | | | | |
|-----------------------------------|-------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> Golf | <input type="checkbox"/> Tennis | <input type="checkbox"/> Fishing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Skiing | <input type="checkbox"/> Biking | <input type="checkbox"/> Running |
| <input type="checkbox"/> Football | <input type="checkbox"/> Basketball | <input type="checkbox"/> Soccer | <input type="checkbox"/> Racing |

Purpose of this appointment: (Annual exam, eye infection, lost glasses, etc.)? _____

Your physician's name _____

Date last seen _____

Date of last eye exam: _____

Name of **vision** insurance: _____

Name of **medical** insurance: _____

Do you wear glasses? Yes No

Do you wear prescription sunglasses? Yes No

Do you wear contact lenses? Yes No

If you wear contacts, are your glasses current? Yes No

Our office policy is to receive payment at the time of service.

Payment will be made by:

- Cash Check Credit Card
 Vision Service Plan (VSP) Medicare Other

Are you interested in contact lenses for either full time, part-time or occasional wear? Yes No

Are you interested in **Laser Vision Correction** to reduce or eliminate the need for eye glasses? Yes No

Do you use a computer at home or at work? Yes No
Approximately how many hours per day? _____

Do you do much desk work, reading or writing? Yes No

Do you experience any eye strain, headaches or blurred vision while using a computer or reading? Yes No

Do you experience any of the following symptoms?

- | | | |
|---|--|---|
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Eye aches or strain | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Trouble adjusting to glasses | <input type="checkbox"/> Spots or floaters | |

I understand if my Insurance company denies payment or if there is no vision coverage, I will be financially responsible for payment of all charges incurred for services received from this office.

signature

Thank you for selecting our office and for trusting us with your eye health and precious vision!

Glaser Vision Optometry

Review of Systems:

Do you, or any one in your family currently or previously, been treated for any of the following conditions:
Please circle the condition if it is listed, or write it in if it is not listed.

Please list any medications you are taking for the condition(s) which may affect you.

Constitutional:

Fever, Weight loss/gain _____

Integumentary (skin):

Neurological

Headaches, Migraines, Seizures _____

Eyes

Flashes/floaters, Excess tearing/watering,
Itching, Burning, Mucous, Redness, _____
or any other condition, which may
trouble you _____

Endocrine

Hyperthyroid, Graves Disease, Hypothyroid, other gland disorder _____

Ears, Nose, Mouth, Throat

Allergies/Hay fever, Sinus congestion,
Dry throat/mouth, chronic cough _____

Respiratory

Asthma, Chronic bronchitis, Emphysema _____

Vascular/Cardiovascular

Diabetes, High blood pressure,
Heart pain, vascular disease _____

Gastrointestinal

Diarrhea, Constipation _____

Genitourinary

Genitals, Kidney, Bladder _____

Bones/Joints? Muscles

Rheumatoid Arthritis, Muscle Pain, Joint Pain _____

Lymphatic/Hematological

Anemia, Bleeding
Problems _____

Allergic/Immunologic

Psychiatric _____

Please list any over-the-counter medications you currently use or usually use. _____

Review of Social History:

This information is kept strictly confidential. However, you may discuss this information with the doctor if you prefer. ___ Yes, I would prefer to discuss my social history information directly with my doctor. (Check line)

Do you drive? _____ If yes, do you have visual difficulty when driving? _____ If yes please describe: _____

Do you use tobacco products? _____ If yes, type/amount/how long? _____

Do you drink Alcohol? _____ If yes, type/amount/how long? _____

Do you use Illegal drugs? _____ If yes, type/amount/how long? _____

Have you ever been exposed to or been infected with ___ Gonorrhea ___ HIV ___ Syphilis

Doctor's Initial's _____

Patient's Initials _____ Month/year _____/_____

Annual review _____/_____

_____/_____