

# CRYSTAL VISION CLINIC

## General Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

M or F \_\_\_\_\_ Spouses name/or if child Parent(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Ph:( ) \_\_\_\_\_ Work Ph:( ) \_\_\_\_\_ Cell Ph:( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone#:( ) \_\_\_\_\_

Employer/School: \_\_\_\_\_ Occupation/School Grade: \_\_\_\_\_

Email Address: \_\_\_\_\_ Sports/Hobbies: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Person responsible for account: \_\_\_\_\_

Please check the method of payment for today's services: Cash\_\_\_ Check\_\_\_ Credit Card\_\_\_ Insurance\_\_\_

(If notification of appropriate insurance is not presented at time of appointment, you will be responsible for payment)

## CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Physician/Clinic: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Clinic/Eye Doctor's Name: \_\_\_\_\_

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type: \_\_\_\_\_ Replace Schedule: \_\_\_\_\_

Have you ever had eye injuries? Yes No Which Eye? \_\_\_\_\_

Have you ever had eye surgeries? Yes No Why? \_\_\_\_\_

Have you taken eye medication? Yes No Why? \_\_\_\_\_

Are you currently pregnant or nursing? Yes No

## HAVE YOU EVER BEEN DIAGNOSED WITH?

Cataracts: Yes No When were you diagnosed? \_\_\_\_\_

Glaucoma: Yes No When were you diagnosed? \_\_\_\_\_

Macular Degeneration: Yes No When were you diagnosed? \_\_\_\_\_

Amblyopia (lazy eye): Yes No When were you diagnosed? \_\_\_\_\_

Strabismus (eye turn): Yes No When were you diagnosed? \_\_\_\_\_

**\* PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE\***

**CHIEF COMPLAINT:** How can we help you today? In this space please circle/explain any signs/and or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as vision loss, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Blurred Vision - Distance/Near	Eye Strain	Floaters or Spots	Headaches
Burning/Itchy Eyes	Watery Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Mucous Discharge	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Droopy Lids	Poor Color Vision	Light Sensitive
Sandy/Gritty Feeling	Tired Eyes	Eye Pain/Soreness	Wandering Eye

Other (explain):

**PERSONAL MEDICAL HISTORY ( REVIEW OF SYSTEMS):** PLEASE CHECK YES IF ANY OF THE FOLLOWING **APPLIES** TO YOU. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NO.

High blood pressure	Yes ___ No___	Kidney Disease	Yes ___ No___
Stroke	Yes ___ No___	Urinary Tract Infection	Yes ___ No___
Heart Disease	Yes ___ No___	STD - Herpetic/Chlamydia	Yes ___ No___
Vascular Disease	Yes ___ No___	Osteoarthritis	Yes ___ No___
Cancer	Yes ___ No___	Fibromyalgia	Yes ___ No___
Trauma/Large Volume Blood Loss	Yes ___ No___	Ankylosing Spondylitis	Yes ___ No___
Developmental Disability	Yes ___ No___	Crohn's	Yes ___ No___
Multiple Sclerosis	Yes ___ No___	Colitis	Yes ___ No___
Epilepsy	Yes ___ No___	Asthma	Yes ___ No___
Tumor	Yes ___ No___	Emphysema	Yes ___ No___
Anemia	Yes ___ No___	COPD	Yes ___ No___
Leukemia	Yes ___ No___	ADHD	Yes ___ No___
Eczema	Yes ___ No___	Depression	Yes ___ No___
Rosacea	Yes ___ No___	Schizophrenia	Yes ___ No___
Psoriasis	Yes ___ No___	AIDS or HIV	Yes ___ No___
Non-Insulin Dependent Diabetes	Yes ___ No___	Rheumatoid Arthritis	Yes ___ No___
Insulin Dependent Diabetes	Yes ___ No___	Lupus	Yes ___ No___
Thyroid Problem	Yes ___ No___	Hearing Loss	Yes ___ No___
Hormonal Dysfunction	Yes ___ No___	Upper Respiratory Infection	Yes ___ No___

<p><b>Allergies</b> (please list)</p> <p>Drug:</p> <p>Environmental:</p>
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<p><b>Alcohol Use:</b> Yes No___</p> <p><b>Tobacco Use:</b> Yes No___</p>
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**Please list any medications and/or drugs that you are taking (including herbal) :**

<b>1)</b> _____ <b>For</b>	<b>6)</b> _____ <b>For</b>
<b>2)</b> _____ <b>For</b>	<b>7)</b> _____ <b>For</b>
<b>3)</b> _____ <b>For</b>	<b>8)</b> _____ <b>For</b>
<b>4)</b> _____ <b>For</b>	<b>9)</b> _____ <b>For</b>
<b>5)</b> _____ <b>For</b>	<b>10)</b> _____ <b>For</b>

**FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:**

**DISEASE / CONDITION**

Retinal Detachment:	Yes/No _____	Cataracts:	Yes/No _____
High Blood Pressure:	Yes/No _____	Glaucoma:	Yes/No _____
Diabetes:	Yes/No _____	Crossed Eyes:	Yes/No _____
Blindness:	Yes/No _____	Macular Degeneration:	Yes/No _____

**Reviewed by:**

**Dr.** \_\_\_\_\_ **Date** \_\_\_\_\_