Vision Source®

Dr. Shonda D. Achord, Optometrist

PATIENT INFORMATION	INSURANCE INFORMATION
Last____	Please note services usually not covered by insurance include; EXAMS WITHOUT MEDICAL NECESSITY (exam only for the need of glasses), REFRACTIONS (exam to determine if you need glasses or a change of lenses)
First____________________Middle____________	Primary Medical Insurance____________________________________
Preferred Name____________________________	Member Name________________________________
Date of Birth_________________ Age_________	ID#____
Social Security No._______________Sex_______	Group#______________Date of Birth______________
Race__________ Ethnicity: Hispanic or Latino / Not Hispanic or Latino	Employer_____________________________________
Marital status: Single Married Divorced Other	Secondary Medical Insurance___________________________________
Address_____________________________________	Member Name______________________________
City________________State________Zip________	ID#____
Phone: Home__________________________ Cell____________________________ Work___________________________	Group#______________Date of Birth______________
Email____	Employer____________________________________
Employer or School___________________________	Vision Insurance____________________________
Occupation or Grade__________________________	Member Name______________________________
Spouse or Parent's Name______________________	ID#____
Family members who are currently patients; ____ ____	Group#______________Date of Birth______________
How did you choose our office? (Circle One) Patient Doctor Partners Saw Sign Insurance List Internet website	Employer____________________________________
Who may we thank for referring you to our office? ____	**PLEASE PRESENT DRIVER'S LICENSE AND ALL MEDICAL AND VISION INSURANCE CARDS TO RECEPTIONIST.**

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The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Name of Family Physician ____________________
Date of Last Physical Check-up ____________________

CURRENT MEDICATIONS (Rx or over-the-counter)
(List name of medications including eye drops, vitamins, & birth control pills) ____________________
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? ____________________
____

Have you had EYE surgery? ❑ Yes ❑ No
If yes, please list type and date ____________________
____

Do you use cigarettes / tobacco, alcohol or other substances? ❑ Yes ❑ No

Have you used tobacco products in the past? ❑ Yes ❑ No

In the past year, have you been diagnosed with or treated for the following health issues :

Allergies	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Blood / Lymph System	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
(type:____________________)		
Cholesterol	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Digestive System	❑ Yes	❑ No
Ears / nose / throat	❑ Yes	❑ No
Endocrine System	❑ Yes	❑ No
Eczema / Rashes	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Fevers (persistent or recurrent)	❑ Yes	❑ No
Genitourinary	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Skin	❑ Yes	❑ No
Kidney	❑ Yes	❑ No
Muscle / Bone	❑ Yes	❑ No
Neurological	❑ Yes	❑ No
Psychological	❑ Yes	❑ No
Respiratory System	❑ Yes	❑ No
Sinus	❑ Yes	❑ No
Thyroid	❑ Yes	❑ No
Unusual weight losses / gains	❑ Yes	❑ No

PATIENT EYE HISTORY

Date of Last Eye Exam ____________________
By Whom? ____________________

Have you ever tried contact lenses? ❑Yes ❑ No
Do you currently wear contact lenses? ❑Yes ❑ No

What kind? ____________________
Solutions used ____________________

Are you satisfied with the vision and comfort of your contact lenses? ❑Yes ❑No

Would you prefer clear contact lenses or colored contact lenses? ❑Clear ❑Colored

How often do you dispose of your contact lenses:
❑ Daily ❑ Every 2 weeks
❑ Monthly ❑ Other____________

Have you ever experienced, been diagnosed with or treated for any of the following eye problems:

❑ Blurry vision	❑ Burning
❑ Cataracts	❑ Corneal abrasions
❑ Crossed eyes / eye turn	❑ Double vision
❑ Eye infections	❑ Eye injury
❑ Flash of light	❑ Floaters /spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis / uveitis
❑ Itchiness	❑ Lazy eye
❑ Macular Degeneration	❑ Ocular dryness
❑ Retinal Detachment	❑ Sunlight sensitivity

FAMILY MEDICAL / EYE HISTORY

Is there a family medical history of the following:

	Relationship	
Diabetes	____________________	❑
Heart Disease	____________________	❑
Glaucoma	____________________	❑
Lazy Eye	____________________	❑
Macular Degeneration	____________________	❑
Retinal Problems	____________________	❑
Other	____________________	❑

____________________ ____________________ ____________________
Signature Date Reviewed by Doctor