



Guardian: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, St: \_\_\_\_\_ Zip: 815\_\_\_\_\_  
 Phone(H): \_\_\_\_\_ (W): \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Vision or Primary Insurance  
 Ins.: \_\_\_\_\_ #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Medical or Secondary Insurance  
 Ins.: \_\_\_\_\_ #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

E-Mail: \_\_\_\_\_  
 Contact me by:  Email  Mail  Phone  Any  
 How did you hear about our office?

Emergency Contact Name and Phone: \_\_\_\_\_

Our office requires payment at time of service unless we "accept assignment" on your insurance. You are responsible if your insurance doesn't pay. We charge 18% per year (1.5% per month) on balances over 30 days old. Contact lens fit and follow up care is billed separately from your eye exam. Your information is protected by our privacy policy.

*I have received a copy of Valley Vision Center's "Notice of Privacy Practices".*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Allergies**

Penicillin  
 Sulfa  
 Eye drops  
 Novacaine  
 Seasonal  
 Codine  
 None  
 Other...

**Current Medications**

**Past Medical History**      1st Visit:      #:

<input type="checkbox"/> Ambyopia	<input type="checkbox"/> Ear or Sinus	<input type="checkbox"/> Lupus	<u>Other</u>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eye infections	<input type="checkbox"/> Macular Degen	
<input type="checkbox"/> Autoimmune	<input type="checkbox"/> Eye injuries	<input type="checkbox"/> Migraine	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Multiple Sclero:	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Neurologic	
<input type="checkbox"/> Cataract	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric	
<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Diabetes 1	<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Radial Keratoto	
<input type="checkbox"/> Diabetes 2	<input type="checkbox"/> LASIK	<input type="checkbox"/> Thyroid	
<input type="checkbox"/> Droopy lid	<input type="checkbox"/> Lazy eye		

**Eye wear History - Which have you worn?**

<input type="checkbox"/> Glasses	<input type="checkbox"/> No- line	<input type="checkbox"/> Gas Perm	<input type="checkbox"/> Disposable
<input type="checkbox"/> Bifocals	<input type="checkbox"/> Soft Contacts	<input type="checkbox"/> Hard	<input type="checkbox"/> Overnight wear
<input type="checkbox"/> Trifocals	<input type="checkbox"/> Toric Soft	<input type="checkbox"/> Monovision	

**Family History - parents, grandparents, siblings**      Other

<input type="checkbox"/> Blindness	<input type="checkbox"/> High Blood Pres.	<input type="checkbox"/> Retina Detach
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Color Blind	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Lupus
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Macular Degen.	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retina Disease	

**Social History**      Occupation

<input type="checkbox"/> Computer Occas.	<input type="checkbox"/> Student	<input type="checkbox"/> Shooting
<input type="checkbox"/> Computer-Extensive	<input type="checkbox"/> Music	<input type="checkbox"/> Scuba
<input type="checkbox"/> Reading-Extensive	<input type="checkbox"/> Skiing	<input type="checkbox"/> Swimming
<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Golf	<input type="checkbox"/> Bike
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Fishing	
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Tennis	

**Approx. Date of Last Eye Exam:**

Less than 1 yr.     About 2 yr.     About 3-5 yrs.     Guess:  
 About 1 yr.       About 3 yr.       More than 5 yrs.

**Current eye problems**  
 Check ALL that apply, then CIRCLE the WORST one.

<input type="checkbox"/> No problem	<input type="checkbox"/> Flashes/Floaters
<input type="checkbox"/> Glasses Update	<input type="checkbox"/> Loss of Vision
<input type="checkbox"/> Contacts Update	<input type="checkbox"/> Loss of Side Vision
<input type="checkbox"/> Blur at Far	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Blur at Near	<input type="checkbox"/> Sandy/Gritty Feeling
<input type="checkbox"/> Blur Far & Near	<input type="checkbox"/> Foreign Body Sensation
<input type="checkbox"/> Red eye	<input type="checkbox"/> Other (list)
<input type="checkbox"/> Itching	
<input type="checkbox"/> Burning	
<input type="checkbox"/> Redness	
<input type="checkbox"/> Eye Pain	
<input type="checkbox"/> Eye Strain/Headaches	

**Which eye bothers you the most?**      **Severity?**

Right Eye.     Left Eye.     Both Eyes.     Mild.     Severe.  
 Moderate.

**How long has it bothered you?**

Started Today.     3-7 Days.     2-4 Weeks.     3-6 Months.  
 1-2 Days.       1-2 Weeks.     1-3 Months.     Over 6 Months.

**Getting worse?**

Getting better.     Getting worse.     Staying the same.

**Are you interested in contact lenses information?**

Try CL.     Upgrade CL.     No