VISION SOURCE®

Advanced Eye Care For Your Family

1205 S. Five Mile Rd., Boise, ID 83709 | Ph: (208) 322-8381 | Fax: (208) 322-8389 | www.visionsource-boise.com

Please help us meet your vision and eye health needs by providing the following information.

Date____/____/_____

Name_____ _____ DOB_____/_____/_____ Age_____
First M.I. Last Preferred Name

Address_____ Soc. Sec. #_____
Street City State Zip

Cell Ph_____ Home Ph_____ Email Address_____

Wk Ph_____ Employer/School_____ Occupation_____

Spouse's Name, if married_____ Parent's Name, if pt is a minor_____

Name of Medical Doctor_____Last Medical Exam____/___/_____ Last Eye Exam____/____/____

Medical Insurance_____ Vision Insurance_____

How will you settle your account today? ❑ Check ❑Cash ❑Credit Card ❑Payment Program

If you were referred to our office, whom may we thank for the referral? _____

❑Location ❑Qwest Yellow Pages ❑Regional Directory Yellow Pages ❑Other_____

I understand that I am ultimately responsible for all fees and agree to pay for all services rendered. Although I may have insurance coverage, I understand and agree to be responsible for all fees billed to my insurance company should payment be declined.

_____
Please Sign Here

VISION & EYEWEAR INFORMATION

Please list any complaints about your current glasses or contacts.

_____

Do you have more than one pair of glasses? Yes No

If you wear glasses, would you benefit from thinner, lighter lenses? Yes No

Do you spend significant time working on a computer? Yes No

Hobbies_____

Do you spend a lot of time outdoors? Yes No

Laser vision correction is an option for many people. Do you desire information or a free consultation? Yes No

Do you wear contact lenses? Yes No
What type do you wear?
Gas Permeable Disposable Soft Soft (yearly)

Are you interested in a "test drive" of the latest in contact lens design? Yes No

FAMILY HISTORY

Do your parents, grandparents, siblings, or children have any of the following conditions?

Condition			Relationship
Blindness	Yes	No	_____
Cataracts	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Disease	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Thyroid Disease	Yes	No	_____

Other _____

_____

_____

Please turn form over and complete back side.

SOCIAL HISTORY

All information about our patients is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Please initial here _____ if this is your preference.

Do you use tobacco products? Yes No If yes, type/amount/how long? _____

Do you drink alcohol? Yes No If yes, type/amount/how often? _____

Do you use illegal drugs? Yes No If yes, type/amount/how long? _____

Do you drive? Yes No If yes, do you have difficulty with your vision when driving? Please explain/describe. _____

_____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

MEDICAL HISTORY & REVIEW OF SYSTEMS

Please list ALL medications taken, including homeopathic remedies, birth control, and over the counter medications.

_____

_____

Are you allergic to any medications? Yes | No If yes, please list or explain:_____

Please list all major injuries and surgeries you have undergone:_____

_____

Please check any of the following that you have had: ❑ lazy eye ❑ crossed eyes ❑ drooping eyelid ❑ glaucoma ❑ retinal disease ❑ cataracts ❑ chronic eye infections ❑ eye injury

Are you pregnant and/or nursing? Yes No

Please check any of the following that have caused significant or chronic problems for you:

EYES	**2018**	_____	_____
Loss of vision	❑	❑	❑
Blurred or distorted vision	❑	❑	❑
Double vision	❑	❑	❑
Dryness	❑	❑	❑
Itching or burning	❑	❑	❑
Chronic redness	❑	❑	❑
Eye pain or soreness	❑	❑	❑
Flashes or floaters	❑	❑	❑
Glare or light sensitivity	❑	❑	❑
Watering or tearing	❑	❑	❑
EARS/NOSE/MOUTH/THROAT			
Allergy/hay fever	❑	❑	❑
Chronic sinus infection	❑	❑	❑
Dry mouth	❑	❑	❑
NEUROLOGICAL			
Headaches or migraines	❑	❑	❑
BONES/JOINTS/MUSCLES	❑	❑	❑
CONSTITUTIONAL			
Fever, weight loss/gain	❑	❑	❑
INTEGUMENTARY	❑	❑	❑

HEMATOLOGIC	**2018**	_____	_____
Bleeding problems	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑
GENITOURINARY			
Kidney, bladder, genitals	❑	❑	❑
ENDOCRINE			
Thyroid or other glands	❑	❑	❑
Diabetes Type I/Type II (circle)	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Emphysema	❑	❑	❑
CARDIOVASCULAR			
High blood pressure	❑	❑	❑
Heart attack	❑	❑	❑
High cholesterol	❑	❑	❑
Stroke	❑	❑	❑
Vascular disease	❑	❑	❑
GASTROINTESTINAL			
Chronic diarrhea or constipation	❑	❑	❑

If you checked any of the above conditions or have a condition not listed, please explain.

_____

Dr. Signature_____Date_____

Dr. Signature_____Date_____

Dr. Signature_____Date_____

Dr. Signature_____Date_____

Dr. Signature_____Date_____