Visual and Medical History

Patient Name____ Date________________________

Personal Vision History:

	Yes	No
Do you wear eyeglasses	O	O
Do you wear contact lenses	O	O

Do you ever experience any of the following eye conditions?

	Yes	No		Yes	No
Blur when driving	O	O	Tunnel vision	O	O
Blur when reading	O	O	Tired eyes	O	O
Light sensitivity	O	O	Redness	O	O
Halos around lights	O	O	Itching	O	O
Glare off of headlights	O	O	Burning	O	O
Glare off of computer screen	O	O	Dryness	O	O
Double vision	O	O	Eye pain	O	O
Floaters	O	O	Mucous discharge	O	O

Have you ever been diagnosed with any of the following?

	Yes	No	Which Eye
Blindness	O	O	R / L / Both
Cataract	O	O	R / L / Both
Glaucoma	O	O	R / L / Both
Macular Degeneration	O	O	R / L / Both
Retinal Detachment	O	O	R / L / Both
Diabetic Retinopathy	O	O	R / L / Both
Lazy Eye	O	O	R / L / Both
Have you had LASIK?	O	O	R / L / Both
Other eye surgery?	O	O	R / L / Both

Personal Medical History	Yes	No	
Are you currently taking any medications?	O	O	Please list______________________________
Are you allergic to any medication?	O	O	Please list______________________________
Do you use tobacco products?	O	O	
Do you drink alcohol?	O	O	
Do you use illegal drugs?	O	O	
For Women: Are you pregnant?	O	O	

Have you ever been exposed to or infected with?

	Yes	No
Gonorrhea	O	O
Hepatitis	O	O
HIV	O	O
Syphilis	O	O

Do you currently, or have you ever had any problems in the following areas:

System	**Yes**	**No**	**System**	**Yes**	**No**
CONSTITUTIONAL	O	O	BONES/JOINTS/MUSCLES	O	O
Fever, Weight Loss/Gain	O	O	Rheumatoid arthritis	O	O
INTEGUMENTARY (skin)	O	O	Muscle pain	O	O
NEUROLOGICAL	O	O	Joint pain	O	O
Headaches	O	O	LYMPATIC/HEMATOLOGIC	O	O
Migraines	O	O	Anemia	O	O
Seizures	O	O	Bleeding problmes	O	O
ENDOCRINE	O	O	ALLERGIC/IMMUNOLOGIC	O	O
Thyroid/Other glands	O	O	PSYCHAITRIC	O	O
EARS, NOSE, MOUTH, THROAT	O	O	VASCULAR/CARDIOVASCULAR	O	O
Allergies/Hay Fever	O	O	Diabetes	O	O
Sinus congestion	O	O	Heart pain	O	O
Runny nose	O	O	High blood pressure	O	O
Post-Nasal drip	O	O	Vascular disease	O	O
Chronic cough	O	O	GASTROINTESTINAL	O	O
Dry throat/mouth	O	O	Diarrhea	O	O
RESPIRATORY	O	O	Constipation	O	O
Asthma	O	O	GENITOURINARY	O	O
Chronic bronchitis	O	O	Genital/Kidney/Bladder	O	O
Emphysema	O	O			

If you answered YES to any of the above or have a condition not listed, please expain & list medications:

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Family Vision History:

Has anyone in your immediate family been diagnosed with any of the following?

	Yes	No	Relationship
Blindness	O	O	____________
Cataract	O	O	____________
Glaucoma	O	O	____________
Macular Degeneration	O	O	____________
Retinal Detachment / Disease	O	O	____________

Doctors Signature ____________________ Date ____________________

Patient Information

Patient Name____ Date of Birth_______________________

Address____ City / State / Zip_____________________________

Home Phone_______________________________________ Cell / Work Phone___________________________

Responsible Party if minor_____________________________ Relation to patient____________________________

Email____ May we contact you via email? Yes No

Occupation_______________________________________ Hobbies_________________________________

How were you referred to our office?

( ) Myself, I am a long time patient

( ) Family_________________________________

( ) Friend_________________________________

( ) Insurance

( ) Doctor_________________________________

( ) Yellow Pages

( ) Internet
If Internet, what web site?____________________

( ) Other
If Other, what was it?_______________________

Vision Insurance

***Note: Please notify front desk if you have an insurance card. We may not need you to answer all questions.**

Vision Insurance___________________________________ Phone #__________________________________

Member________________________________ ID#_____________________ Date of Birth________________

Members Employer_________________________________ Policy / Group#____________________________

Medical Insurance

***Note: We only need this information if you are here for a medical office visit.**

Medical Insurance__________________________________ Phone #__________________________________

Member________________________________ ID#_____________________ Date of Birth________________

Authorization of Payment:

I hereby authorize all payment for services rendered to be paid to Dr. Brett Bowman. I understand that benefit authorization is not a guarantee of payment and that I am ultimately responsible for all service and materials fees.

Signature____ **Date**_____________________________________