Welcome to

South Valley Vision Source™

Name_____ Date_____/_____/_____

Gender: M F Other Birthdate_____/_____/_____ Social Security#_____

Phone: Home_____ Work_____ Cell_____

Address_____ City_____ State _____ Zip _____

Email Address_____

Employer (or school)_____ Occupation (or grade)_____

Person responsible for payment on account_____ Relationship to patient_____

If you are enrolled in a vision plan (VSP, Superior Vision, EyeMed), please list the vision plan as Primary, and the medical plan as Secondary

Primary Insurance Company_____ Insured's Name _____

Insured's Social Security # (or ID #) _____Insured's Birthdate_____/_____/_____

Insured's Address (if different)_____ City_____ State ____ Zip _____

Secondary Insurance Company _____ Insured's Name_____

Insured's Social Security # (or ID #) _____Insured's Birthdate_____/_____/_____

Insured's Address (if different)_____ City_____ State ____ Zip _____

Health History Questionnaire

PERSONAL OCULAR HISTORY:

Injuries, surgeries, and/or infections_____

_____

PERSONAL MEDICAL HISTORY:

Injuries, surgeries, and/or hospitalizations_____

_____

SYSTEMIC FAMILY HISTORY:

None Arthritis Cancer Diabetes Hypertension High Cholesterol Thyroid Disease

Other_____

OCULAR FAMILY HISTORY:

None Cataract Glaucoma Macular Degeneration Strabismus (Crossed) or Amblyopia (Lazy Eye)

Other_____

(please complete reverse side as well)

OCULAR MEDICATIONS: (including over-the-counter)_____

ANY MEDICATIONS: (including over-the-counter)_____

_____

SOCIAL HISTORY:

Use of alcohol? NO YES Type/Quantity/Frequency_____

Use of tobacco? NO YES Type/Quantity/Frequency_____

Use of narcotics? NO YES Type/Quantity/Frequency_____

CURRENT EYEWEAR STATUS:

Do you currently wear glasses? NO Distance Only Reading Only Computer Progressive Bifocal

CURRENT CONTACT LENS STATUS:

Do you currently wear contact lenses? NO YES Brand_____

Power: R_____ L_____ (include astigmatism, if applicable)

Personal Review of Systems

**ALLERGIES OR DRUG HYPERSENSITIVITIES (including type of reaction)_____

_____

PLEASE LIST ANY CURRENT MEDICAL DIAGNOSES IN THE FOLLOWING CATEGORIES (for example: heart disease, diabetes, menopause, skin problems, arthritis, headaches, multiple sclerosis, anxiety/depression, asthma, etc), or mark "none"

Cardiovascular_____ None Constitutional_____ None

Endocrine_____ None Gastrointestinal_____None

Genitourinary_____ None Integumentary_____ None

Musculoskeletal_____ None Neurological_____ None

Psychiatric_____ None Respiratory _____ None

Additional Information

Reason for your visit today (ie: new glasses/contact lenses, LASIK evaluation, dry eye – gritty/sandy/burning/tired feeling – red eye, flashes/floaters, eye pain or discharge, etc)_____

_____

Please list any visual needs relating to your occupation, recreation, or hobbies_____

_____

How did you find out about our office?_____