INFORMATION UPDATE

VISION REHABILITATION ASSOCIATES, P.C.

Doctors of Optometry

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We are pleased to welcome you back to our practice. The following information will aid your doctor in providing the most complete care possible. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION

Name _____ Age _____ Birth date _____ Date Completed _____

Occupation / Employer _____ Grade / School _____

Address Change? _____

Phone (Home) _____ Phone (Work) _____ Phone (Cell)_____

REASON FOR YOUR VISIT

Please place a "√" in any ❒ that applies to **why you scheduled today's visit**.

- ❒ Annual Check-up / Not having any problems
- ❒ Challenges with clarity of far or near vision
- ❒ Replace lost or broken spectacles
- ❒ Need back-up spectacles or sunglasses
- ❒ Need more contact lenses or would like to try contact Lenses
- ❒ Trouble using eyes comfortably
- ❒ Other _____

To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

_____

_____

Do you wear glasses? ❒ No ❒ Yes ❒ All the time ❒ Occasionally

❒ Prescription ❒ Non-Prescription ❒ Distance tasks ❒ Near tasks ❒ Computer

Do you use sunglasses? ❒ No ❒ Yes

Do you wear contact lenses? ❒ No ❒ Yes Type/Brand _____

Replacement Schedule _____ Hours Worn /Day _____

Pairs Left _____ Solutions used _____

EYE / VISION CONCERNS

Please place a "√" in any ❒ to indicate if you are experiencing any of the following.

- ❒ Blurred Vision – Distance
- ❒ Blurred Vision – Near
- ❒ Burning Eyes
- ❒ Crusty Eyelids
- ❒ Dizziness, Balance issues
- ❒ Double Vision
- ❒ Dry Eyes
- ❒ Eye Infection / Injury
- ❒ Eye Pain
- ❒ Eye Strain
- ❒ Eyes not aligning
- ❒ Floaters or Spots
- ❒ Fluctuating Vision
- ❒ Itchy Eyes
- ❒ Light Sensitivity
- ❒ Poor Night Vision
- ❒ Red Eyes
- ❒ Seeing Flashes or Halos
- ❒ Styes
- ❒ Temporary Loss of Vision
- ❒ Twitching Eyelid
- ❒ Watery Eyes

HEALTH HISTORY

Place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncles, aunts or siblings).

	Yourself	Family Members
Arthritis	❒	❒
Asthma	❒	❒
Blood disorder	❒	❒
Cancer	❒	❒
Cataracts	❒	❒
Depression / Anxiety	❒	❒
Diabetes	❒	❒
Glaucoma	❒	❒
Headaches	❒	❒
Head Injury	❒	❒
Heart Condition or Pacemaker	❒	❒
Herpes	❒	❒
High Blood Pressure	❒	❒
High Cholesterol	❒	❒
Macular Degeneration	❒	❒
Shingles	❒	❒
Skin Disorder	❒	❒
Stroke	❒	❒
Thyroid Condition	❒	❒

Other _____

Date of your last physical? _____

Current Physician's name: _____

Address if known: _____

Phone number if known: _____

Number of children _____ Are you pregnant? ❒ Yes ❒ No

Do you use tobacco? ❒ Yes ❒ No

Do you drink alcohol? ❒ Yes ❒ No

ALLERGIES / SENSITIVITIES

Please place a "√" in any ❒ to indicate if you have any allergies or sensitivities in the categories below.

- ❒ Drugs (Please List) _____
- ❒ Foods (Please List) _____
- ❒ Seasonal / Environmental (Please include which season bothers you most) _____

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please place a "√" in any ❒ to indicate if you use any prescribed or over-the-counter substances in the categories below. Please include dosage and frequency.

- ❒ Medications (Please List) _____
- ❒ Vitamins / Supplements (Please List) _____
- ❒ Eye Drops (Please List) _____

— Thank You —