

Welcome!

Today's Date _____

Last Name _____ First _____ Middle _____

Name you prefer to be called _____

If a Child, Parent's Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Email _____

Birth Date ____/____/____ Social Security Number ____/____/____ Gender Male Female

Employer _____ Occupation _____ Work Phone # _____

Work Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Vision Insurance Carrier _____ Member ID #or SSN _____

Primary Member Name _____ Relationship _____ Primary Member Birthdate ____/____/____

Health Insurance Carrier _____ Member ID# or SSN _____

Primary Member Name _____ Relationship _____ Primary Member Birthdate ____/____/____

Medicare/Medicaid _____ Member ID #or SSN _____

Primary Member Name _____ Relationship _____ Primary Member Birthdate ____/____/____

Referral Whom may we thank for referring you?

- VSP List Yelp.com Internet: Which site? _____
 Live/Work Nearby Shop Nearby Doctor/School Nurse
 Friend /Relative – their name _____

Payment and Privacy Policy

Insurance Signature on File

- I certify that the information given by me in applying for Insurance payments are true and correct. I request that payment of authorized Insurance benefits be made to Dr Sandra Lee for any services and materials furnished. I authorize any holder of medical information about me to release to HCFA or Insurance agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown. I understand that I am responsible for the balance of fees not paid by insurance.
- I have read and understand the Privacy Policy (HIPPA). I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Dr. Sandra Lee, Optometrist, APC.

Signature on File Date

Signature on File Date

Payment is Due Upon Completion of Exam Today.

*** Please turn this form over & complete side two ***

Medical History

Do you have any allergies to medications? No Yes If yes, explain: _____

Are you currently seeing a physician for any health problems? No Yes

If yes, what? _____

List any medications you take (including birth control, aspirin, or over the counter medications and home remedies):

MEDICATION _____ FOR _____

MEDICATION _____ FOR _____

MEDICATION _____ FOR _____

Are you pregnant and/or nursing? No Yes If yes, how many months pregnant? _____

Do you: Currently wear contact lenses? Have worn contact lens in the past

Type of contact lenses: Hard Soft Extended Wear How often do you replace lenses? _____

Date of Last Eye Exam _____ Doctor _____

Family History Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

DISEASE/CONDITION	N	Y	WHO	DISEASE/CONDITION	N	Y	WHO
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye/Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Growths	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History with my doctor (Check box)

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

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

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

Have you ever been exposed to or infected with: N/A Gonorrhea Hepatitis HIV Syphilis

Review of Systems Are you having any problems in the following areas:

	N	Y		N	Y
EYES			RESPIRATORY		
Loss of Vision/Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Poor Distance/Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR		
Strained / Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			ALLERGIC / IMMUNOLOGIC		
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, MOUTH, THROAT			CONSTITUTIONAL		
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
Post – Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>

Lifestyle Questionnaire

This questionnaire is to assist your eye care professional in helping you select the perfect lenses, frames, and/or contacts to best suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

Patient Name _____

Date of Visit _____

1. Which of the following visual demands do you encounter on a regular basis? (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Computer work
How many hrs/day? _____ | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Paperwork | <input type="checkbox"/> Boardwork |
| <input type="checkbox"/> Potential eye hazards | <input type="checkbox"/> Artificial lighting |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Natural lighting |
| | <input type="checkbox"/> Close-up work |

2. Which of the following hobbies or activities do you participate in? (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Auto repair | <input type="checkbox"/> Landscaping/gardening |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Musical instrument |
| <input type="checkbox"/> Biking | <input type="checkbox"/> Painting |
| <input type="checkbox"/> Boating/water sports | <input type="checkbox"/> Pilot |
| <input type="checkbox"/> Bowling | <input type="checkbox"/> Racquetball |
| <input type="checkbox"/> Competitive sports | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Sewing/arts/crafts |
| <input type="checkbox"/> Drawing | <input type="checkbox"/> Snow sports |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Spectator sports |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Fishing | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Welding |
| <input type="checkbox"/> Home repairs | <input type="checkbox"/> Woodwork |
| <input type="checkbox"/> Hunting/shooting | <input type="checkbox"/> Jogging/Running |
| <input type="checkbox"/> Other: _____ | |

3. Do your eyes seem bothered by glare from any of the following situations? (Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Car headlights | <input type="checkbox"/> Night Driving |
| <input type="checkbox"/> Computer monitor | <input type="checkbox"/> Sunshine |
| <input type="checkbox"/> Fluorescent lights | <input type="checkbox"/> Traffic lights |
| <input type="checkbox"/> Haze | <input type="checkbox"/> Other: _____ |

4. Do you have any metal or silicon allergies? Yes No