Welcome to VisualEyes Optique

Today's Date_____

Patient Information

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Date of Birth _____Age _____
Sex M F
Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?
- ❑ Another Dr.
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Mailer
- ❑ Google
- ❑ Social Media: Which Site? _____
- ❑ Other _____

VisualEyes Optique's mission is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will strive to offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. All of us at VisualEyes Optique wish to establish a lifelong relationship with YOU, earning your trust by providing our services with integrity and professionalism. We are glad you are here!

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber ID#_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)
- ❑..work at a computer? How many hours/day? ___
- ❑..think you might benefit from thinner, lighter lenses?
- ❑..would like to occasionally wear contacts?
- ❑..spend time outdoors? How much? __Hrs/week
- ❑..have prescription sunwear?
- ❑..have more than 1 pair of current Rx eyewear?
- ❑..have children?
- ❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Burning
- ❑ Cataracts
- ❑ Corneal Abrasions
- ❑ Crossed eye/Eye turn
- ❑ Double Vision
- ❑ Eye Infections
- ❑ Eye Injury
- ❑ Flash of light
- ❑ Floaters/Spots
- ❑ Glaucoma
- ❑ Grittiness
- ❑ Headaches
- ❑ Iritis/Uveitis
- ❑ Itchiness
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Occasional dryness
- ❑ Retinal Detachment
- ❑ Sunlight Sensitivity
- ❑ Tearing
- ❑ Trouble seeing at night
- ❑ Uncomfortable glasses
- ❑ Other eye disorders_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

Do you: Use cigarettes/tobacco: ❑ Yes ❑ No
If yes, how often:
Drink alcohol: ❑ Yes ❑ No
If yes, how often:
Use other substances? ❑ Yes ❑ No
Previous history of blood transfusion: ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Are you currently pregnant?	❑	❑
Asthma	❑	❑
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sexually transmitted disease	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑
Vertigo/Dizziness	❑	❑

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Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Previous history of eye surgery? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?
❑ No ❑ Yes

	Relationship (Mother's or Father's side)
Blindness	
Cataracts	
Corneal Problems	
Diabetes	
Glaucoma	
Heart Disease	
LazyEye	
Macular Degeneration	
Retinal Problems	

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not VisualEyes Optique.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to VisualEyes