#  Hertneky Vision Source www.hertnekyvisionsource.com

 **212 Cameron Street Brush, Colorado 80723 Phone:(970) 842-5166 Fax: (970) 842-5167**

Welcome to our office. The information you complete here will allow us to give you the best care!

Patient Name:       Phone Home:       Cell:

Mailing Address       City:      Zip:       Sex: [ ] M [ ] F

Birth Date:       Social Security#:       Email Address:

Race: [ ] White [ ] Asian [ ] African American/Black [ ] Native Hawaiian/Pacific Islander [ ] American Indian/Alaska Native [ ]  Unknown

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latin Preferred Language:       Previous Eye Doctor:

Last Eye Exam:       Name of Medical Doctor:       Last Medical Exam:

**Employed:** [ ] Y [ ]  N Employer:       Work Phone:       Ext:

**Married:** [ ] Y [ ]  N Spouse’s name:       Date of Birth:       Social Security #:

**For Ages 0-18:** Mother’s Name:       Birth Date:       Social Security #:

 Father’s Name:       Birth Date:       Social Security#:

**Family Members:** Name:       Birth Date:       Relationship:       Name:       Birth Date:       Relationship:

**Insurance Information:** Please present **ALL** Vision and Medical Insurance cards at time of visit.

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Insurance**  |   | **Secondary Insurance**  |  |
| Name of Primary Member:       | Primary Member’s DOB:      | Name of Primary Member:      | Primary Member’s DOB:      |
| Company:      | Policy#:      | Company:      | Policy#:       |

Who is responsible for this account?       Please check a payment option: [ ] Cash [ ] Check [ ] Credit Card [ ] HSA/Flex Plan [ ] Care Credit

**How did you hear about us:** [ ] Family [ ] Friends [ ] Hospital/Doctor [ ] Yellow Pages [ ] Insurance List

 [ ] Sign/Building [ ] Mailing/Newsletter [ ] Newspaper [ ] Radio [ ] Website [ ] Other

**Reason for Visit:**

**Purchasing Plans:** [ ] New eyeglasses [ ] New Prescription Sunglasses [ ] New Non-prescription Sunglasses [ ] New Computer Eyeglasses

 [ ] New Reading glasses [ ] New Sport Eyeglasses [ ] New supply of contact lenses [ ] New contact lens fit

Are there any hobbies, sports, activities, work environments, or leisure where your eyes gets strained, vision gets blurry, or you do not feel your glasses or contacts work good enough?

**Medical History:**

Is there anything about your eye health that worries you? [ ] Y [ ] N If so, what is it?

Please list **all medications** including oral contraceptives, aspirin, over the counter medications and home remedies:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drug Name | Dose | Taken when/how often | Drug Name | Dose | Taken when/how often |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |

Any **Allergies** to medications: [ ] No [ ] Yes If yes, explain:

**Do you wear glasses**? [ ] No [ ] Yes **Do you wear contact lenses**? [ ] Y [ ]  N

 If yes, how old is your present pair of lenses?       Brand Name:       Power:       Base Curve:

**Social History: DO YOU…**

Drive? [ ] Y [ ] N If yes, do you have visual difficulty when driving? [ ] Y [ ] N If yes, please describe:      Commute [ ] East [ ] West?

Use tobacco products? [ ] Y [ ] N **If yes, type:** [ ] cigarette [ ] cigar [ ] pipe [ ] smokeless **how often:** **[ ]** Never Smoker [ ] Former Smoker

Drink alcohol? [ ] Y [ ] N **If yes**, # drinks       per [ ] day [ ] week [ ] month

 **PLEASE CONTINUE TO THE NEXT PAGE (OR) OTHER SIDE**

**Family History:**

Please note any family history (**parents, siblings and/or children**, living or deceased) for the following medical conditions:

**Disease/Condition Relation to you Disease/Condition Relation to you**

Cataract [ ]

Glaucoma/Suspect [ ]

Macular Degeneration [ ]

Cancer [ ]

Diabetes [ ]

High Blood Pressure [ ]

Thyroid Disease [ ]

**Check any of the following that you may have/had:**

[ ] Lazy eye[ ]  Drooping eyelid [ ] Prominent eyes [ ] Retinal disease [ ] Eye infections [ ] Eye injury [ ]  Nystagmus

# Review of Systems

Do you currently or **ever** had any problems in the following areas: (Please check all that apply)

##

**OCULAR:**

 [ ] Loss of Vision

 [ ] Blurred Vision

 [ ] Distorted Vision/Halos

 [ ] Double Vision

 [ ] Dryness

 [ ] Mucous Discharge

 [ ] Redness

 [ ] Sandy or Gritty Feeling

 [ ] Itching

 [ ] Burning

 [ ] Foreign Body Sensation

 [ ] Excess Tearing/Watering

 [ ] Glare/Light Sensitivity

 [ ] Eye Pain or Soreness

 [ ] Chronic Infection of Eye

 [ ] Chronic Infection of Lid

 [ ] Sties or Chalazion

 [ ] Flashes/Floaters in Vision

 [ ] Tired Eye

 [ ] Other

**CONSTITUTION:**

 [ ] Developmental disability

 [ ] Cancer

 [ ] Fatigue Syndrome

 [ ] Other

**ENT:**

 [ ] Hearing loss

 [ ] Sinusitis

 [ ] Dry Mouth

 [ ] Laryngitis

 [ ] Other

**NEURO:**

 [ ] Multiple Sclerosis

 [ ] Seizures/Epilepsy

 [ ] Cerebral Palsy

 [ ] Tumor

 [ ] Stroke/CVA

 [ ] Migraines

 [ ] Other

**PSYCH:**

 [ ] Depression

 [ ] Attention Deficit

 [ ] Anxiety/Panic disorder

 [ ] Bipolar disorder

 [ ] Other

**CARDIOVAS:**

**[ ]** Hypertension

 [ ] Stroke/CVA

 [ ] Heart Disease

 [ ] Vascular Disease

 [ ] Congestive Heart Failure

 [ ] Other

**RESPIRATORY:**

 [ ] Cigarette Smoker

 [ ] Asthma

 [ ] Bronchitis

 [ ] Emphysema

 [ ] Chronic Obstruction

 [ ] Sleep Apnea

 [ ] Other

**GASTROINTESTINAL:**

 [ ] Crohn’s

 [ ] Colitis

 [ ] Ulcer

 [ ] Acid Reflux

 [ ] Celiac Disease

 [ ] Other

**GENITOURINARY:**

 [ ] Kidney disease

 [ ] Prostate disease/cancer

 [ ] STD (herpetic/chlamydia)

 [ ] Benign Prostate Hypertrophy

 [ ] Currently Pregnant or Nursing

 [ ] Herpes

 [ ] Chlamydia

 [ ] Other

**MUSC/SKEL:**

 [ ] Arthritis

 [ ] Osteoarthritis

 [ ] Fibromyalgia

 [ ] Muscular Dystrophy

 [ ] Ankylosing Spondylitis

 [ ] Osteoporosis

 [ ] Gout

 [ ] Other

**INTEGUMENTARY (Skin):**

 [ ] Eczema

 [ ] Rosacea

 [ ] Psoriasis

 [ ] Cold Sores

 [ ] Shingles

 [ ] Other

**ENDOCRINE:**

 [ ] Type 2 diabetes

 [ ] Type 1 diabetes

 [ ] Thyroid dysfunction

 [ ] Hormonal dysfunction

 [ ] Other

**HEM/LYMPH:**

 [ ] Anemia

 [ ] Large-volume blood loss

 [ ] Ulcer

 [ ] High Cholesterol

 [ ] Other

**ALLERGY/IMM:**

**[ ]** Drug allergies

 [ ] Environmental allergies

 [ ] Rheumatoid Arthritis

 [ ] Lupus

 [ ] Sjoren’s Syndrome

 [ ] Other

 **THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM**