# 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**