Patient Health History

TODAYS DATE: _____

Please give your insurance card to the receptionist at the front desk when you check in.

CONSENT TO RELEASE INFORMATION:

Name: _____ Relationship: _____ Phone: _____

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____ Age: _____

Address: _____ Apt: _____ City: _____ State/Zip: _____ Gender: M F

Date Of Birth: _____ SSN: _____ Preferred Contact Number: _____ Text? Y N

Email Address: _____ Employer or School: _____ Position or Grade: _____

Status: Full Time or Part Time Parent or Spouse Name: _____ Parent or Spouse Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

Employer & Phone Number: _____

REFERRAL INFORMATION

Who may we thank for referring you to our office? _____

How did you choose our office?

◯ Insurance List ◯ Saw Sign/Building ◯ Web: Facebook, Google Reviews, other: _____

PATIENT EYE HISTORY

Date of Last Eye Exam: _____ By Whom? _____ Purpose of this visit? _____

Any concerns with your current contact lenses or glasses? _____

Have you ever tried contact lenses? YES NO Do you currently wear contact lenses? YES NO

Are you satisfied with the vision and comfort of your contact lenses? YES NO

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

- ◯ Blurry Vision
- ◯ Crossed Eye/Eye Turn
- ◯ Flash Of Light
- ◯ Trouble Seeing At Night
- ◯ Double Vision
- ◯ Floaters/Spots
- ◯ Uncomfortable Glasses
- ◯ Grittiness
- ◯ Tearing
- ◯ Occasional Dryness
- ◯ Cataracts
- ◯ Eye Infections
- ◯ Corneal Abrasions
- ◯ Retinal Detachment
- ◯ Headaches
- ◯ Iritis/Uveitis
- ◯ Lazy Eye
- ◯ Macular Degeneration
- ◯ Sunlight Sensitivity
- ◯ Itchiness, Burning
- ◯ Eye Injury
- ◯ Glaucoma
- ◯ Other Eye Disorders: _____

FAMILY MEDICAL/EYE HISTORY (CHECK ALL THAT APPLY) & LIFESTYLE QUESTIONS

	MOTHER	FATHER
1. Blindness	◯	◯
2. Cataract	◯	◯
3. Corneal Problems	◯	◯
4. Diabetes	◯	◯
5. Glaucoma	◯	◯
6. Heart Disease	◯	◯
7. Lazy Eye	◯	◯
8. Macular Degeneration	◯	◯
9. Retinal Problems	◯	◯
10. None of the above	◯	◯

Do you.... (check if you answer is yes)

- ◯ ... work at a computer
- ◯ ... think you might benefit from lighter lenses?
- ◯ ...interest in the latest contact lens design
- ◯ ... spend time outdoors? Hours per week ___
- ◯ ... have prescription sunwear?
- ◯ ... prefer not to wear glasses at times?
- ◯ ... want info on Laser Vision Correction surgery?
- ◯ ... have more than 1 pair of current Rx eyewear?
- ◯ ... have children?
- ◯ ... have family members in need of eyecare?

PATIENT MEDICAL HISTORY

Name of Family Physician: _____ Date of Last Physical Check-Up: _____

Address: _____

Current Medications (Rx or Over the Counter) List name of medications including eye drops, vitamins, & birth control: _____

Allergies to medications? YES NO If yes, what medication: _____

Have you had any surgeries? YES NO Do you use cigarettes/tobacco, alcohol, or other substances? YES NO

Have you ever been diagnosed or treated for the following health problems:

◯ Allergies	◯ Diabetes	◯ Genitourinary	◯ Psychological	◯ Cholesterol
◯ Arthritis	◯ Ears/Nose/Throat	◯ High Blood Pressure	◯ Respiratory	◯ Digestive
◯ Blood/Lymph	◯ Endocrine	◯ Integumentary (Skin)	◯ Sinus	◯ Fevers
◯ Bronchitis	◯ Eczema/Rashes	◯ Kidney	◯ Throat Infections	◯ Neurological
◯ Cancer	◯ Fatigue	◯ Muscle/Bone	◯ Thyroid	◯ Unusual weight loss/gains

I certify that I have read and understand the above information and have accurately answered to the best of my knowledge. Providing incorrect information can be dangerous to my health. I authorize Blink Vision or any authorized agents to release any information including the diagnosis and the records to any treatment rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to make payment directly to Blink Vision. I accept full responsibility for payment of all services rendered on behalf of myself or my dependents.

Signature: _____

The mission of Blink Vision is to contribute to a lifetime of healthy vision. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services and products. The visual needs and wellness of each patient will always be our first priority. It is our express goal to far surpass your expectations and provide you the highest quality, personalized eye care in a friendly, enjoyable environment by utilizing the latest technology available. Everything we do shall communicate this goal.