Welcome to Precise Vision

Please take a moment to fill out this profile to help us meet your eye care needs.
Insurance inquiries must be made prior to the examination.

Patient Information

Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Guardian (if applicable): _____ Occupation: _____

Patient's Birth Date: _____ Last Eye Exam: _____

Do you have vision insurance? ❑ No ❑ Yes If yes, insurance carrier and ID: _____
Subscriber's Name and Birthdate: _____
Do you have health insurance? ❑ No ❑ Yes If yes, insurance carrier and ID: _____
Subscriber's Name and Birthdate: _____
Reason for today's visit: ❑ Glasses ❑ Contact Lenses ❑ Red Eye/Office Visit ❑ LASIK ❑ Myopia Management

Ocular History

Do your wear glasses? ❑ No ❑ Yes If yes, then how old is your present pair of lenses? _____

Do you wear contact lenses? ❑ No ❑ Yes If yes, then how old is your present pair of lenses? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other_____ Are they comfortable? ❑ No ❑ Yes

Check any of the following that you may have had: ❑ Crossed Eyes ❑ Lazy eye ❑ Drooping eye lid ❑ Glaucoma
❑ Retinal Disease ❑ Eye Infections ❑ Eye Injury ❑ Eye Surgery: RK, PRK, LASIK, Cataract / Date Occurred:

Medical History

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

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies)

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you may have had: _____

_____

_____

Are you currently: Pregnant ❑ No ❑ Yes Nursing: ❑ No ❑ Yes

Social History -This information will be kept confidential. However you may discuss this portion directly with the doctor if you prefer.

Do you drink alcohol? ❑ No ❑ Yes Do you smoke? ❑ No ❑ Yes

Do you have a history of drug abuse? ❑ No ❑ Yes Do you drive? ❑ No ❑ Yes

--OVER--

Review of Systems – Please Circle *Yes or No* if **you** have any of the following problems

Y N General: Weight loss, Fever, Headache
Y N Ear/Nose/Throat: Hearing loss, Sinus Problems
Y N Heart: Chest pain, irregular heart beat
Y N Respiratory: Short of breath, Wheezing, Asthma, Cough
Y N Digestive: Heartburn, Diarrhea, Reflux
Y N Neurologic: Paralysis, Numbness
Y N Skin: Rashes, Eczema
Y N Psychiatric: Depression, Anxiety, Mental illness
Y N Endocrine: Diabetes, Thyroid
Y N Cancer: Any type
Y N Blood: Anemia, Sickle Cell, Excessive bleeding
Y N Urinary: Kidney, Bladder issues
Other: Please list _____

Problems of the eye/vision

Y N Burning
Y N Excessive tearing/watering
Y N Redness
Y N Itching
Y N Sandy or gritty feeling
Y N Mucus discharge
Y N Eye pain or soreness
Y N Fluctuating vision
Y N Loss of vision
Y N Loss of peripheral vision
Y N Flashes/floaters in vision
Y N Double Vision
Other: Please list _____

Family History

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

Disease/Condition	**No**	**Yes**	**Relationship**
Blindness	❑	❑	_____
Cataracts	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Problems	❑	❑	_____
Corneal Problems	❑	❑	_____
Eye Surgery	❑	❑	_____
Lazy Eye	❑	❑	_____
Crossed Eyes	❑	❑	_____
Color Blindness	❑	❑	_____
Diabetes	❑	❑	_____
High Blood Pressure	❑	❑	_____
High Cholesterol	❑	❑	_____
Heart Disease	❑	❑	_____
Thyroid	❑	❑	_____
Cancer	❑	❑	_____
Arthritis	❑	❑	_____
Lupus	❑	❑	_____
Multiple Sclerosis	❑	❑	_____
Other	❑	❑	_____

Optional Testing

VISUAL FIELD TEST – A highly advanced computerized instrument that provides a thorough assessment of your central and peripheral vision. The cost of this screening test is **$15.00** ❑ **YES** ❑ **NO**

DILATED EXAMINATION – This allows a thorough view of the retina. This examination can detect many conditions within the eye that may not be detected during a routine eye examination. Drops are instilled in the eyes and near vision may be blurred up to 6 hours. The cost of this test is **$20.00** ❑ **YES** ❑ **NO**

RETINAL PHOTO – This allows a thorough view of the retina and can be used instead of dilated examinations in most individuals. This is an automated test and no dilation of pupils is required, therefore no side effects.
The cost of this test is **$35.00** ❑ **YES** ❑ **NO**

Patient/Guardian Signature:_____ Date:_____

I have read and understand the Notice of Privacy Policy (attached) _____ (patient initial)