



Patient Information

Name _____

Street _____

City _____

State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Patient's SSN _____

Sex M F

Date of Birth _____

Age _____

Employer _____

Occupation _____

Email Address _____

Name of Family Physician _____

Spouse/Partner/Parent's

Name _____

Spouse/Partner/Parent's

Employer _____

Spouse/Partner/Parent's

DOB _____

Who may we thank for referring you to our office?

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

At Clearvue Vision Center your vision and eye health are of utmost importance to us. Our commitment is to improve the quality of our patients' lives through better vision. Using the latest technology, our goal is to provide you with the highest quality eye care available, in a warm and inviting environment.
Our Focus is on you.

Lifestyle Questions

Check the box if your answer is yes

Do you work at a computer?
How many hours per day? _____
How do your eyes feel at the end of the day?

What hobbies do you have?

Do you participate in hobbies or physical activities that may put your eyes at risk for injury?

Do you spend time outdoors? How many Hrs/week _____

Do you have prescription sunwear?

Do you prefer not to wear your glasses at times?

Do you want information on laser vision correction?

Are you currently experiencing, 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

Dry Eyes

Retinal Detachment

Sunlight Sensitivity

Tearing

Trouble seeing at night

Other eye disorders _____

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Do you currently wear contact lenses? Yes No

What kind? _____

Solutions used _____

Is there a family medical history of any of the following:

Relationship
(Mother's or Father's side)

Blindness _____

Cataracts _____

Corneal Problems _____

Diabetes _____

Glaucoma _____

Heart Disease _____

Lazy Eye _____

Macular Degeneration _____

Retinal Problems _____

Patient Medical History

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills)

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

Allergies to medications? Yes No

If so, what

medications? _____

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

	Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Clearvue Vision Center. All copays are due at time of appointment. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible to pay for those office fees.

Initial _____

Please give 24 hours notice if you cannot make your scheduled appointment. If you fail to do so, there will be a \$40.00 No Show fee.

HIPAA Notice of Privacy Practices acknowledgement

A copy of our HIPAA Notice is available to you at any time upon request.

I acknowledge that Clearvue Vision Center has given me a copy of the Privacy Notice.

Patient or Parent Signature

Date