NewView Optometric Center

Welcome to New View Optometric Center

Instructions: To provide the most comprehensive eye examination and to comply with insurance company requirements, please fill out both sides of this form.

Personal Information

Name:_____ **Birth Date:**_____ **Today's Date:** _____

Address: _____ **City:** _____ **State:**_____ **Zip Code:**_____

Home Phone: (_____) _____ **Work Phone:** (_____) _____ **Mobile Phone:** (_____) _____

E-Mail Address: _____ **(For exam info, statements, product info, notifications, educational materials, etc.)**

Occupation:_____

Medical Insurance: _____ **Is it an HMO** ☐ **(You have to go to a specific list of doctors) or a PPO?** ☐ **(You can choose any doctor)**

Social Security # of patient:_____ **Social Security # of Policy Holder:**_____ **Patient ID #:**_____

Who referred you to our office? ☐ **Friend/Family/Co-worker Name?**_____ ☐ **Ins. Co. list** ☐ **Internet** ☐ **Other** _____

Personal Eye History

REASON(S) FOR YOUR VISIT? ☐ **Check-up** ☐ **Contact lens evaluation** ☐ **Pathology evaluation** ☐ **New glasses** ☐ **New contact lenses** ☐ **Questions**
☐ **School referral** ☐ **Doctor / Nurse referral** ☐ **Failed DMV eye test** ☐ **Other:**_____

How long has it been since your last complete eye examination? ☐ **Never** ☐ **Less than 1 year** ☐ **1 year** ☐ **2 years** ☐ **3 years** ☐ **4 years** ☐ **5 or more years**

Do you wear glasses? ☐ **Yes** ☐ **No If yes, do you wear them…?** ☐ **Full time** ☐ **Part Time** ☐ **Seldom**

For what purpose were they prescribed? ☐ **General use** ☐ **Distance only** ☐ **Near only** ☐ **Computer use** ☐ **Occupational** ☐ **Safety** ☐ **Sport Specific**

Describe your computer use: ☐ **Extensive (4+ hrs/day)** ☐ **Moderate (1-4 hrs/day)** ☐ **Low Use (Less than 1 hr/day)** ☐ **Seldom** ☐ **Never**

CHIEF COMPLAINT: ☐ **None** ☐ **Distance Blur** ☐ **Near Blur** ☐ **Intermediate Blur** ☐ **Computer Blur/Eye fatigue** ☐ **Trouble reading** ☐ **Headaches**
☐ **Eyestrain** ☐ **Eyes burn** ☐ **Eyes water** ☐ **Eyes itch** ☐ **Eyes feel sandy/gritty** ☐ **Eye pain** ☐ **Eyes red** ☐ **Floaters/Flashes**
☐ **Double vision** ☐ **Light sensitivity** ☐ **Pressure around eyes** ☐ **Decreased side vision** ☐ **Other:** _____

Allergies: ☐ **Hayfever** ☐ **Dust** ☐ **Grasses** ☐ **Mold** ☐ **Pollen** ☐ **Cats** ☐ **Other:** _____

Medication allergies: ☐ **Penicillin** ☐ **Sulfa drugs** ☐ **Codeine** ☐ **Novacaine** ☐ **Contact lens solutions** ☐ **Other:**_____

Ocular surgeries: ☐ **Lasik** ☐ **RK** ☐ **PRK** ☐ **Cataract(s)** ☐ **Retinal detachment** ☐ **Glaucoma** ☐ **Pterygium** ☐ **Eyelid** ☐ **Other:**_____

Have you had an eye injury: ☐ **Yes** ☐ **No If yes, please describe:**_____ **Date:** _____

Do you have a history of any eye disease? ☐ **Yes** ☐ **No If yes, please describe:**_____ **Date:**_____

Review of Systems

Do YOU have a history of any of the following health conditions? ☐ **High blood pressure** ☐ **Diabetes** ☐ **Cardiovascular disease** ☐ **High cholesterol**
☐ **Stroke** ☐ **Cancer** ☐ **Arthritis** ☐ **Hyper / Hypothyroid (Circle one)** ☐ **Respiratory disease** ☐ **Psychological disease** ☐ **Neurologic disease**
☐ **Immunologic disease** ☐ **Blood disease** ☐ **Skin disease** ☐ **Osteoporosis** ☐ **Sexually transmitted disease** ☐ **Genito-urinary disease**
☐ **Musculo-skeletal disease** ☐ **Trauma** **Do you use…** ☐ **Cigarettes/Tobacco?** ☐ **Alcohol?** ☐ **Other substances?**

Are YOU currently taking ANY MEDICATIONS for ANY health condition including prescription, non-prescription (over-the-counter), eye drops, herbs, vitamins, birth control pills, hormones, etc. _____

_____

Family History

Does any BLOOD RELATIVE have any of the above health conditions? Who?/Which conditions? _____

_____

Does any BLOOD RELATIVE have any of the following OCULAR health conditions? Who? Which condition? ☐ **Cataracts** ☐ **Glaucoma**
☐ **Macular degeneration** ☐ **Retinal detachment** ☐ **Diabetic retinopathy** ☐ **Other** _____
Name of family doctor? _____

Lifestyle

Please check the activities in which you participate: ☐ **Active in multiple sports** ☐ **Run/Hike/Walk** ☐ **Snow sports** ☐ **Golf** ☐ **Tennis/Racquetball**
☐ **Fishing/Boating/Watersports** ☐ **Cycling** ☐ **Dirt sports** ☐ **Equestrian** ☐ **Dance/Cheer/Gymnastics/Martial Arts** ☐ **Baseball/Softball**
☐ **Basketball/Football** ☐ **Soccer** ☐ **Pool/Billiards** ☐ **Reading** ☐ **Music** ☐ **Board Games** ☐ **Video Games** ☐ **Crafts** ☐ **Internet** ☐ **Gardening**

Contact Lenses

Do you wear contact lenses? ☐ **Yes** ☐ **No** **If yes, do you wear them…** ☐ **Full time?** ☐ **Part time?** **If no, are you interested in contact lenses?** ☐ **Yes** ☐ **No**
Do you sleep in you lenses? ☐ **Yes** ☐ **No** **If yes, how many nights in a row will you wear them before removing them?** _____
Are your contacts ☐ **Soft?** ☐ **Rigid?** ☐ **Disposable?** ☐ **Non-Disposable?** ☐ **Tinted?** ☐ **Monovision?** ☐ **Bifocal?** ☐ **Multifocal?** ☐ **For astigmatism?**
How old are the pair of contacts you are currently wearing?_____ **Are they comfortable all day?** ☐ **Yes** ☐ **No** **Do you see well with them?** ☐ **Yes** ☐ **No**
Which brand of contacts are you wearing? _____ **One pair will last how long?** _____ **Care Solutions?** _____

Signature: _____ **Date:** _____