Today's Date _____

Patient Information

Last _____

First _____MI _____

Street _____

City_____

State _____Zip Code_____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Age _____ Sex: M F

Email Address _____

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

Primary Medical Insurance_____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

Secondary Medical Insurance_____

Do you participate in a flex spending account?
❑ Yes ❑ No

How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

VERY IMPORTANT! NEW PATIENTS ONLY:

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

If not referred, how did you choose our office?
❑ Another Dr. ❑ Insurance List ❑ Saw Sign/Building ❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? ❑ Web Page: Which Web Site? ❑ Other

Payment is required when services are rendered and deposits are required on all eyeglasses and contact lenses ordered. I hereby authorize Dr. Arlene Schwartz to release to insurance carriers any information concerning my condition and treatments. I understand that I am financially responsible for all services rendered today if I require a referral and yet elect to visit the specialist without the referral from my primary care physician. The insurance information furnished here represents a full disclosure of the Insurance/Third Party benefits to which I am entitled. I also request payment of government/medical benefits either to myself or to the Party for services rendered.

Signature_____ **Date:**_____

Medical History

CHIEF COMPLAINT: How can we help you today? In this space please briefly tell us any symptoms you are experiencing.
(MEDICAL INSURANCE WILL ONLY COVER A MEDICAL REASON FOR THE EXAM WILL NOT COVER ROUTINE VISION COMPLAINTS)

Y / N Are you thinking of new glasses today?
Y / N Are you thinking of new sunglasses today?
Y / N Are you thinking of new contact lenses today?
Y / N Are you interested in laser vision correction?
Y / N Do you experience eyestrain at the computer?

HISTORY OF PRESENT ILLNESS

Location	Which eye has the problem?	R___L___Both___
Quality	Does the problem cause vision loss or blur?	Loss___Blur___
Context	Did the problem occur suddenly or gradually?	Sudden___Gradual___
Severity	How sever is the problem?	Mild___Moderate___Severe___
Modifying Factors	Is it worse at any specific distance?	Distance___Near___Both___
Duration	How long does the problem last?	Intermittent___Constant___
Timing	How long has the problem been occurring	Short term___Long term___
Associated symptoms	Are there associated symptoms?	No___Headaches___Nausea___
(Previous Interventions)	Does anything help the problem?	Nothing helps___Nothing has been tried___)

PAST, FAMILY AND/OR SOCIAL HISTORY

Is there anything in your past history or social history which would help us care for you?

- Past History (illnesses, operations, injuries, treatments)_____
- Family History (diseases, hereditary, risk factor, glaucoma)_____
- Social History (past and current activities)_____
- Medication History (heart meds., blood pressure)_____
- **Do you use any of the following products:** Tobacco, Alcohol, Recreation drugs

REVIEW OF SYSTEMS **Circle any of the following symptoms that apply to your eyes**

EYES

Blindness	Loss of vision
Distorted vision	Blurred vision
Double vision	Cataracts
Crossed eyes	Flashes or floaters
Dry eyes	Watery eyes
Red eyes	mucous discharge
Burning or itching	Sandy or gritty feeling
Eye pain or soreness	Glare/light sensitivity
Chronic eye infection	Tired eyes
Halos	Vision Therapy
Eye surgery	Eye injury
Retinal detachment	Glaucoma

Have you ever been exposed to or infected with:

Gonorrhea	___Yes	___No
Hepatitis	___Yes	___No
HIV	___Yes	___No
Syphilis	___Yes	___No

Name:_____

Date:_____

Allergic/Immunologic
- Hay Fever
- Medical allergies

Constitutional Symptoms
- Fever
- Weight loss

Cardiovascular
- Heart pain
- High blood pressure
- Vascular disease

Ears, Nose, Mouth, Throat
- Allergies/Hay Fever
- Sinus problems
- Chronic cough
- Dry throat/mouth
- Chronic ear infections

Endocrine
- Diabetes
- Thyroid problems
- Other glands

Gastrointestinal
- Diarrhea
- Constipation
- Ulcers

Genitourinary
- Kidneys
- Bladder

Hematologic/Lymphatic
- Anemia
- Bleeding problems
- Swelling

Integumentray
- Skin
- Breast

Musculskeletal
- Arthritis
- Rheumatoid Arthritis
- Muscle Pain
- Joint pain

Neurological
- Headaches
- Migraines
- Seizures

Psychiatric
- Nervous disorders
- Depression
- Compulsive behavior

Respiratory
- Asthma
- Shortness of breath
- Emphysema
- Lung cancer

Parent's Name:_____Patient Name:_____

Please check any symptoms that you / or your child maybe experiencing:

_____Blur at distance	_____Eyes Tear Excessively	_____Rereads or Omits Words
_____Blur with near task	_____Eyestrain	_____Reverses Letters, Numbers
_____Poor Reader	_____Dislikes Reading	_____Squinting
_____Eyes Hurt After Close Work	_____Light Sensitive	_____Poor Comprehension
_____Eyes tires easily	_____Poor Memory	_____Seeing Double
_____Holds Reading Close	_____Rub Your Eyes Often	_____Avoid Near Task
_____Car Sickness	_____Makes Copying Errors	_____Frequent Blinking
_____Hyperactive	_____Poor Spelling	_____Other_____

In order to assist the doctor in evaluating all of your child's visual needs, please check all that apply to your child:

_____Honors Curriculum	**_____Fast Reader**
_____Regular Classroom	**_____Slow Reader**
_____Special Education	**_____Doesn't enjoy reading**
_____Resource Room	**_____Prefers to be read to**
_____Speech/Language	**_____Poor reading comprehension**
_____Occupational Therapy	**_____Poor writing skills**
_____Has Repeated_____grade	**_____Homework takes longer then it should**
_____Tutor for_____	**_____Smart in everything but school**
_____Short attention span	**_____Inconsistent / poor sports performance**
_____Fatigue, frustration, stress associated with school	**_____Fine or gross motor skills problems**

_____Other_____

School work: _____Above grade level _____Grade level _____Below grade level

Note: Is there anything additional you would like to share with the Doctor regarding any difficulties your child may be having? Would you would like to discuss this in private? ( ) Yes ( ) No

_____

_____

Which school subject does your child like the best_____

Which school subject does your child like the least_____