Capital Vision Center

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Mr./Mrs./Miss/Ms./Dr._____

Address_____

City_____ State_____ Zip_____

Home# _____ Work#_____

Cell# _____ E-Mail_____

Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer_____ Occupation_____

Date of Birth _____ Age _____

Spouse's Name_____ Family Physician_____

How did you find out about our practice?_____
Are you planning to get new glasses today? Yes ☐ No ☐ Only if Rx changes ☐
Are you planning to get new contacts today? Yes ☐ No ☐ Only if Rx changes ☐
Are you interested in finding out more about laser vision correction? Yes ☐ No ☐ Maybe ☐

Consent to financial responsibility resulting from any and all treatment rendered:

Capital Vision Center makes every effort to call and check benefits on all our patients insurance policies, however this is not a guarantee of coverage or payment. Your insurance company makes the final determination of payment and eligibility. Please make sure you are providing us with the most current insurance cards(s) and information at the time of your appointment.

I authorize the release of any medical information necessary to process all claims. I authorize the release of payment for medical benefits to my physician. I understand that I am responsible for any deductibles, co-payments, co-insurance, or charges not covered by my insurance(s).

I understand that if I wear contact lenses, there are additional fees associated with the contacts. Sometimes the doctor may change the brand of contact I am wearing because either my Rx has changed, the contact I am wearing previously has been discontinued or the lens may not be fitting properly any more. Contact lens fees are usually not covered by insurance and I will be responsible for the fees at the time of my appointment.

Payment is expected when service is rendered.
We accept Visa, Master Card, Discover, Debit cards, Checks, and Cash.
A 50% deposit on Eye glasses orders is required before an order can be placed.
All glasses CUSTOM MADE to each individual prescription.
Deposits are NON REFUNDABLE and orders are processed immediately.

Patient/Parent/ Guardian Signature:_____

Medical History Questionnaire

Last Medical Exam:_____ Last Eye Exam:_____

Name of Previous Eye Doctor:_____ Practice Name:_____

Ocular/ Medical History

Do you wear glasses? No ☐ Yes ☐ If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? No ☐ Yes ☐ Do you sleep in them? No ☐ Yes ☐

What brand of contacts do you wear?_____ What type? RGP ☐ Soft ☐

How frequently do you replace them?_____ Are they comfortable? No ☐ Yes ☐

Are you currently experiencing any of the following problems with your eyes? Check the box if "Yes"

- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Loss of Side Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Tired Eyes
- ☐ Flashes / Floaters
- ☐ Halos
- ☐ Glare/ Light Sensitivity
- ☐ Dryness
- ☐ Sandy or Gritty feeling
- ☐ Foreign Body Sensation
- ☐ Burning
- ☐ Itching
- ☐ Redness
- ☐ Excess Tearing/ Watering
- ☐ Eye Pain or Soreness
- ☐ Mucous Discharge
- ☐ Chronic Infection of the Eye or Lid
- ☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? Check the box if "Yes"

- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Drooping eyelid
- ☐ Other:_____

List any medications you are currently taking (include oral contraceptives, asprin, over the counter medications)

_____
_____
_____
_____
_____
_____

Are you allergic to any medications? No ☐ Yes ☐ If yes, please explain:_____
_____
List all major surgeries and / hospitalizations you have had:_____
_____
_____

Family History

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

- ☐ Blindness _____
- ☐ Cataracts _____
- ☐ Crossed Eyes _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration_____
- ☐ Retinal Detachment_____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ Kidney Disease_____
- ☐ Lupus _____
- ☐ Thyroid Disease_____

Please turn over ⇨

Review of Systems

Please check the box beside any problem you currently have, or have ever had, in the following areas.

Allergic / Immunologic ☐ All Normal
- ☐ Allergy / Hayfever

Cardiovascular / Cardiac ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

Constitutional ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

Ears, Nose, Mouth, & Throat ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

Endocrine ☐ All Normal
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Chronic Fatigue

Gastrointestinal ☐ All Normal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcers
- ☐ Reflux

Genitourinary ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

Hematologic / Lymphatic ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

Integumentary (Skin) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

Musculoskeletal ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

Neurological ☐ All Normal
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

Psychiatric ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

Respiratory ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further:_____

_____

_____

_____

Are you pregnant and / or nursing? ☐ No ☐ Yes

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

Do you drive? ☐ No ☐ Yes If yes, describe any visual difficulty while driving:_____

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long:_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how often and how long:_____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long:_____

Indicate by checking the box if you have been infected with or exposed to:

☐ Gonorrhea ☐ Hepatitis ☐ HIV/AIDS ☐ Syphilis

Patient Signature_____