153 Manchester Street
Concord, NH 03301
Phone: 603-226-0855
Fax: 603-226-0981

First Name: _______________ Last Name:_________________ Preferred/Nickname:________________

Date of Birth: ____/____/_______ Birth Sex: Male Female

Address:________________________________ City:_________________ State:_____ Zip:_________

Phone#: __________________________________ E-Mail:_________________________________

Marital Status: Single Married Divorced Widowed Domestic Partner

Occupation________________________

Medical Insurance: ________________________ ID Number: ________________

Subscriber: Self (or list subscriber name)_______________ Does this have supplement? YES NO

Vision Benefit Plan: __________________

Subscriber: Self (or list subscriber name)________________ Check here if NO INSURANCE

Primary Care Name/Facility: ________________________ Date of last medical exam: ______________

Last Eye Doctor Name/Facility: ____________________________ Date of last eye exam:_____________

How did you find out about Capital Vision Center? ____________________________________________

## Consent to financial responsibility from all services rendered and orders placed

*Please bring all medical and/or vision insurance cards to each visit to maximize your benefits*
*By signing I consent to all office policies and info is complete to the best of your knowledge*
*Payment is expected when service is rendered*
***Full payment is required before an order can be placed for eyeglasses, contact lenses, or supplies***
***All eyeglasses are CUSTOM MADE to each individual patient***
***50% of the material order is NON REFUNDABLE as orders are processed immediately***
***Services are non refundable once rendered***
*We accept Credit Cards, Debit Cards, Checks, and Cash*

→ Patient/Parent/Guardian Signature:_______________________________________________



**Please turn over ⇨**

## *Visual / Ocular Medical History*

Do you wear glasses? No Yes
What type of glasses? Progressive Bifocal Distance Only Computer Reading Only Other ________
How old is your current pair of glasses? ____________________

Do you wear contacts? No Yes What brand of contacts?__________________

What type? Soft RGP Scleral Other How frequently do you replace them?________________________

Are they comfortable? No Yes Do you sleep in them? No Yes

Are you planning to get new glasses today? No Yes Only if Rx changes
Are you planning to get new contacts today? No Yes Only if Rx changes

Are you interested in finding out more about Dry Eye Treatments/Procedures No Yes

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

| | | |
|---|---|---|
| Blurred Vision | Excessive Tearing/Watering | Loss of Side Vision |
| Burning | Flashes/Floaters | Mucous Discharge |
| Dryness | Foreign Body Sensation | Redness |
| Double Vision | Glare/Light Sensitivity | Styes |
| Distorted Vision | Halos | Sandy/Gritty Feeling |
| Eye Pain | Itching | Tired Eyes |
| Eye Strain / Headaches | Loss of Central Vision | Other____________________ |

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

| | | |
|---|---|---|
| Cataracts | Eye Injuries / Scarring | Macular Degeneration |
| Crossed Eyes | Drooping Eyelids | Retinal Detachment/Hole/Tear |
| Corneal Degeneration | Glaucoma | Other:______________________ |
| Dry Eye(s) | Lazy Eye (Amblyopia) | |

List any medications you are currently taking (including over the counter medications and eye drops):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

List any medication allergies:
______________________________________________________________________________
______________________________________________________________________________

List all eye surgeries and major body surgeries you have had:
______________________________________________________________________________
______________________________________________________________________________

## *Family History*

Please note family history (parents, grandparents, siblings, children) who have had the following conditions:

| | |
|---|---|
| Blindness ____________________ | Cancer ____________________ |
| Cataracts ____________________ | Diabetes ____________________ |
| Crossed Eyes ____________________ | Heart Disease____________________ |
| Glaucoma ____________________ | High Blood Pressure________________ |
| Macular Degeneration______________ | Kidney Disease____________________ |
| Retinal Detachment________________ | Thyroid Disease___________________ |
| Autoimmune ________________ | |



**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**
- Allergy / Hayfever .
- Autoimmune Condition

**Cardiovascular / Cardiac**
- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- High Cholesterol

**Constitutional**
- Fever
- Sudden Weight Loss / Gain

**Ears, Nose, Mouth, & Throat**
- Sinus Congestion
- Dry Throat / Mouth

**Endocrine**
- Diabetes
- Thyroid Disease
- Chronic Fatigue

**Gastrointestinal**
- Chronic Diarrhea/Constipation
- Ulcers
- Acid Reflux

**Genitourinary**
- Kidney Disease
- Ovarian / Uterine Cancer
- Prostate Cancer

**Hematologic / Lymphatic**
- Anemia
- Blood Disorder
- Breast Cancer

**Integumentary ( Skin )**
- Cancer
- Rashes
- Easy Bruising

**Musculoskeletal**
- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

**Neurological**
- Headaches
- Dizziness
- Seizures
- Stroke

**Psychiatric**
- Anxiety
- Depression
- Memory Loss
- Dementia/Alzheimers

**Respiratory**
- Asthma
- Bronchitis
- Emphysema
- Chronic Cough

If you have a condition not listed, please explain further:

______________________________________________________________________________

______________________________________________________________________________

Are you pregnant and/or nursing? No Yes

## Social History

***This information is kept strictly confidential and is recommended to be recorded into the chart for many insurance plans.***

Do you drive? No Yes Do you experience glare while driving? No Yes

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

Do you drink alcohol? No Yes If yes, amount/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 in the body or eye with:

Herpes Gonorrhea Hepatitis HIV/AIDS Syphilis

Any information put on this form will be reviewed before being recorded into the patient chart

**Please return to front desk upon completion**