

SOUTHLANDS VISION ASSOCIATES, LLC

TODAY'S DATE: ____/____/____

PATIENT'S INFORMATION: (Please present photo identification along with this form)

Last Name: _____ First Name: _____ M.I.: _____ Birthdate: ____/____/____

Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ - _____ Daytime: (____) _____ - _____ Mobile: (____) _____ - _____

May we text you reminders & order status updates? Yes No May we leave a voice message if needed? Yes No

E-Mail Address: _____ May we e-mail reminders and order status updates? Yes No

Preferred method of contact: Home Phone Daytime Phone Cell Phone Text E-Mail

Gender: Male Female Social Security# : _____ Marital Status: Married Single Widowed Other

Employer: _____ Occupation: _____ Full time Part Time Student Retired

Ethnicity: Hispanic/Latino Pacific Islander Not Hispanic or Latino **Race:** _____ **Pref'd Language:** _____

PERSON RESPONSIBLE FOR PATIENT'S PAYMENT

Last Name: _____ First Name: _____ M.I.: _____ Birthdate: ____/____/____

Address: _____ City _____ State _____ Zip _____

Home #:(____) _____ - _____ Cell #:(____) _____ - _____ Work #: (____) _____ - _____

Social Security #: _____ Gender: Male Female Relationship to Patient : Self Spouse Parent/Guardian

VISION PLAN NAME: _____ (Please present insurance card along with this form)

Primary Insured's Name: _____ Birthdate: ____/____/____

Address: _____ City _____ State _____ Zip _____

Insured's Home #:(____) _____ - _____ Cell #:(____) _____ - _____ Work #: (____) _____ - _____

Employer: _____ Social Security #: _____ Gender: Male Female

Member ID: _____ Group#: _____ Relationship to Patient: Self Spouse Parent/Guardia

MEDICAL PLAN NAME: _____ (Please present insurance card along with this form)

Primary Insured's Name: _____ Birthdate: ____/____/____

Address: _____ City _____ State _____ Zip _____

Insured's Home #:(____) _____ - _____ Cell #:(____) _____ - _____ Work #: (____) _____ - _____

Employer: _____ Social Security #: _____ Gender: Male Female

Member ID: _____ Group#: _____ Relationship to Patient: Self Spouse Parent

*Primary Care Doctor (Name/Addr/Phone/Fax): _____

*Primary Pharmacy (Name/Addr/Phone): _____

OFFICE USE ONLY BELOW:

Patient ID: _____ **NEW / EXIST**

CO-PAYS: Vision: _____ Medical: _____ RV? Y / N FIT: _____ / No Cov CL's: _____

TIME: _____ / WIB DR: KN / CN / AD / ZL GLXM CLXM (PW / NW / ?) FIT ONLY OV OCT IOP

+ / - Butterfly _____ / _____ IOP _____ / 7 COLOR **ALERTS:** IOP OPD VF OPTOS OCT

Last Name: _____ First Name: _____ Birthdate: ____/____/____ Today's date: ____/____/____

REASON FOR TODAY'S VISIT (Check all that apply):

- Blurred Vision: Distance Intermediate Near
- Eye irritation/discomfort
- Other symptoms related to today's visit: _____

Do you wear glasses?

- Yes: Distance Near Computer / Full time Part time
- No, I have never worn glasses.
- Not currently, but I have worn glasses in the past.

Do you wear contact lenses?

- Yes. Brand/powers: _____
- Do you intentionally sleep in them? Yes: ____nights/week No
- No, I have never worn contacts.
- Not currently, but I have worn contacts in the past.
- If you do *not* wear contact lenses, are you interested? Yes No

DATE/PROVIDER LAST EYE EXAM: _____

OCULAR HISTORY

	Self:	Family (list relation):
Cataracts	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Retinal Hole/Tear	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Retina Detached	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Dry Eye Syndrome	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Strabismus	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Amblyopia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Floaters	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Flashes of Light	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other (including surgeries):		_____

MEDICAL HISTORY & REVIEW OF SYSTEMS

DATE OF LAST PHYSICAL: _____

ALLERGIES: None Yes (give substance/reaction i.e. Penicillin/Hives): _____

MEDICATIONS: None Yes (List all, including dosage and frequency): _____

CARDIOVASCULAR

	Self:	Family (list relation):
Cardiovascular Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Elevated Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Hypertension	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

CONSTITUTIONAL

	Self:	Family (list relation):
Fatigue (chronic)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

ENDOCRINE

	Self:	Family (list relation):
Diabetes Mellitus Type I	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Diabetes Mellitus Type II	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Hyperthyroidism	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

GASTROINTESTINAL

	Self:	Family (list relation):
Acid Reflux	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Cancer: Colon	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

(Continued)

GENITOURINARY

	Self:	Family (list relation):
Pregnant/Nursing	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Prostate Disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

EAR, NOSE, THROAT

	Self:	Family (list relation):
Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Hearing Loss	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Sinusitis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

HEMATOLOGIC/LYMPHATIC

	Self:	Family (list relation):
Anemia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Breast Carcinoma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Leukemia	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

IMMUNOLOGIC

	Self:	Family (list relation):
Herpes Simplex (cold sore)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Sarcoidosis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Sjogren's Syndrome	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

INTEGUMENTARY

	Self:	Family (list relation):
Rosacea	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Psoriasis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Scleroderma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

MUSCOSKELETAL

	Self:	Family (list relation):
Arthritis (Osteo)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Arthritis (Rheumatoid)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Myasthenia Gravis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

NEUROLOGICAL

	Self:	Family (list relation):
Brain Tumor	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Headache (Migraine)	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

PSYCHIATRIC

	Self:	Family (list relation):
ADD	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Depression	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

RESPIRATORY

	Self:	Family (list relation):
Asthma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Lung Cancer	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> _____
Other:		_____

SOCIAL HISTORY

Do you smoke tobacco? Yes: ____packs/week for ____years
 No Formerly (Quit ____ years ago)

Do you drink alcohol? Yes: ____drinks/week for ____years
 No Formerly (Quit ____ years ago)

Do you use recreational drugs?
 No Yes: Type & frequency _____

Have you ever had a blood transfusion? Yes No

Do you have any sexually transmitted diseases? Yes No HIV