VISION CORNER®
powered by caring®

Get-Acquainted Questionnaire

(must be updated at each visit)

Date _____

Patient's Name _____ Date of Birth _____
Last First M.I.

Social Security Number _____ Sex: M_____ F _____

Address _____

City_____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____

E-Mail Address _____

If married, name of spouse _____
If child, name of parents _____
Emergency Contact/Phone # _____

Occupation _____ Place of Employment _____
Major Medical Insurance _____ Vision Insurance _____

Referred by:

Family Friend Yellow Pages Internet Insurance Self (location)

Name please _____

OFFICE POLICY

Our opticians will work with you to select the best frames and lenses. There are no refunds unless it is requested on the same day of purchase. Once your order is placed there are no cancellations; if we make an exception to this policy, a 20% restocking fee will be applied. Vision Corner is not liable for any damage when using your own frame.

If you have insurance coverage, we will submit claims for you. All co-payments are due in full on initial visit. Certain charges will be assessed to the patient but will be billed to your major to your insurance provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party's Signature Relationship Date

HEALTH HISTORY

PAST HISTORY

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

Past History (illness, operations, injuries, medications, treatments) _____

Past Ocular (Illness, operations, injuries, medications, treatments) _____

Family History diseases, risk factors, hereditary, such as:

Diabetes	Y	N	Who?	_____
Cholesterol	Y	N	Who?	_____
Hypertension	Y	N	Who?	_____
Thyroid	Y	N	Who?	_____
Glaucoma	Y	N	Who?	_____
Cataract	Y	N	Who?	_____
Macular Degeneration	Y	N	Who?	_____
Other:	Y	N	Who?	_____

Name of family practitioner: _____ Date of last physical: _____

Social History (past and current activities) Do you use any of the following products?

Tobacco: Yes No Alcohol: Yes No Recreational Drugs: Yes No

List family members currently living with you: _____

If female. Are you currently pregnant? Yes No

EYE HEALTH HISTORY

Date of last Vision exam: _____ From Doctor: _____ Date of present glasses: _____

Do you wear glasses? Yes No All the time Occasionally Reading Driving TV Computers

Do you wear contacts? Yes No Type: _____ Hours / Day _____ Solution used: _____

MEDICATIONS (Systemic and Ocular)

List medications you are currently taking:	Reaons for taking each medication:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:

List allergies to medications or other substances

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS: Do you have a problem CURRENTLY with…

Blurred vision	Y	N	Retinal detachment	Y	N	Genitals	Y	N
Blindness	Y	N	Sandy or gritty feeling	Y	N	Kidney	Y	N
Brown spot on eye	Y	N	Swollen lids	Y	N	**Musculoskeletal**		
Bulging eye	Y	N	Tearing	Y	N	Joint pain	Y	N
Chronic eye infections	Y	N	Temporary loss of vision	Y	N	Stiffness	Y	N
Cloudy vision	Y	N	Tired eyes	Y	N	Arthritis	Y	N
Crossed eyes	Y	N	**Constitutional**			Muscle pain	Y	N
Difficulty driving	Y	N	Fever	Y	N	**Integumetary**		
Difficulty reading	Y	N	Chills	Y	N	Rash	Y	N
Difficulty using computers	Y	N	Weight loss	Y	N	Changing moles	Y	N
Distorted vision	Y	N	**Ear, Nose, Throat, Mouth**			Skin	Y	N
Double vision	Y	N	Stuffy nose	Y	N	**Neurological**		
Droopy eyelids	Y	N	Ear ache	Y	N	Headache	Y	N
Dry eyes	Y	N	Cough	Y	N	Seizure	Y	N
Eye discharge	Y	N	Dry mouth	Y	N	Stroke	Y	N
Eye injury	Y	N	Cardiovascular	Y	N	Paralysis	Y	N
Eye pain	Y	N	Chronic ear infections	Y	N	Migraines	Y	N
Eye twitching	Y	N	Sinus problems	Y	N	**Psychiatric**		
Eyes burning	Y	N	**Cardiovascular**			Anxiety	Y	N
Flashes	Y	N	High blood pressure	Y	N	Depression	Y	N
Floaters	Y	N	Rapid heart beat	Y	N	Insomnia	Y	N
Foreign body sensation	Y	N	Vascular disease	Y	N	Nervous disorders	Y	N
Glare	Y	N	Heart pain	Y	N	**Endocrine**		
Halos around lights	Y	N	**Respiratory:**			Diabetes	Y	N
Headache	Y	N	Congestion	Y	N	Thyroid abnormalties	Y	N
Irritation	Y	N	Wheezing	Y	N	Frequent urination	Y	N
Itchy eye	Y	N	Shortness of breath	Y	N	Thirsty all the time	Y	N
Lid lesion	Y	N	Asthma	Y	N	Other glands	Y	N
Light sensitivity	Y	N	**Genitourinary:**			**Hematologic / Lymphatic**		
Photophobia	Y	N	Burning on urination	Y	N	Bleeding	Y	N
Red eye	Y	N	Urinary frequency	Y	N	Anemia	Y	N
Red spot on eye	Y	N	Incontinence	Y	N	Swelling	Y	N