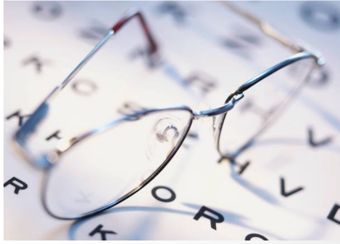

Welcome Back to ABC Vision Source Aloha
Dr. Chad Lawson & Dr. Mari Ward

RETURN Patient Information (All information will be Confidential)

Patient ______________________ Today's Date __________ Date of Birth ______________

Address ______________________ City/State/Zip ______________________

Phone: Day ______________ Evening ______________ E-mail address ______________________

Reason for today's visit ______________ Parent/Guardian ______________________

Insurance Information **VISION** **MEDICAL**

VISION	MEDICAL
S. S. # ______________________	Insurance Co. Name ______________________
Name of insurance co.______________________	Name of insured ______________________
ID/Policy/Group# ______________________	ID/Policy/Group# ______________________

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? ˜ **yes** ˜ **no**

Visual Information

Please check all that you are experiencing with your current correction: ˜ **No change**

Yes		Yes		Yes		Yes	
˜	Blur far away	˜	Eyes itch	˜	Discharge from eyes	☐	Reading held at 10" or less
˜	Blur up close	˜	Eyes water easily	˜	Light sensitivity	˜	Double vision
˜	Headaches	˜	Dry eyes	˜	Pain in or around eyes	˜	Eyes burn
˜	Squinting	˜	Floaters or spots	˜	Eye strain/tired eyes	˜	Night vision problems

Have you had any eye injury, infection or surgery? ˜ yes ˜ no Explain ______________________

Lifestyle Factors! Your answers will assist us in selecting the best eyewear for you!

Occupation ______________________ Spouses' Occupation ______________________

Are you required to wear safety glasses at work? ˜ yes ˜ no

Do you work at a computer or video display terminal? ˜ yes ˜ no

What hobbies, social activities or sports do you participate in? ______________________

Are you tired of wearing glasses and interested in contacts? ˜ yes ˜ no

Are you interested in getting updated glasses? ˜ yes ˜ no

Do you have a back-up pair of glasses available? ˜ yes ˜ no

Do you have prescription sunglasses? ˜ yes ˜ no

Does road glare bother you? ˜ yes ˜ no

Do you use any of the following on a regular basis: ___Tobacco ___Alcohol ___Other Substances

Health Information

Please list any **NEW** medications you are taking and their purpose: ______________________

Have you had any **NEW** changes in your health or any major health problems? ˜ yes ˜ no ˜ **No change**

Do you or does anyone in your family have a history of:

Self	Family		Self	Family		Self	Family	
˜	˜	High Blood Pressure	˜	˜	Arthritis	˜	˜	Amblyopia (lazy eye)
˜	˜	Heart Disease	˜	˜	Epilepsy	˜	˜	Eye Disease
˜	˜	Stroke	˜	˜	Cancer	˜	˜	Cataract
˜	˜	Diabetes	˜	˜	Hypoglycemia	˜	˜	Allergies/Hay Fever
˜	˜	Thyroid Problems	˜	˜	Glaucoma	˜	˜	Strabismus (crossed or wall eyes)

Do you use any of the following on a regular basis: __ Tobacco __Alcohol __Other Substances

Are you allergic to any medications? ˜ yes ˜ no Please list ______________________

Authorization - I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X ____

Signature of Patient (Or parent if a minor) Date Doctor Initials/Date