RICHMOND VISION CARE OPTOMETRY

WELCOME TO OUR OFFICE!

NAME (Last)_____ (First)_____ MI _____
EMAIL_____ Cell Phone_____

VISION Insurance_____ MEDICAL Insurance_____

Address_____
Home Phone_____ Work Phone_____
Date of Birth_____ Guardian (if under 18)_____
Occupation_____Emergency Contact_____
Last Eye Exam_____ Primary Care Physician_____

HEALTH INFORMATION

What is the reason for today's visit?_____

Vision complaints? ☐ Distance blur ☐ Reading blur ☐ Eyestrain ☐ Computer strain/fatigue
☐ Night glare ☐ Other:_____

Do you have: ☐ Diabetes ☐ Hypertension (High Blood Pressure) ☐ High Cholesterol

Please check if you have any problems with the following body systems:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Gastrointestinal	☐	☐	Ears, Nose, Throat	☐	☐	Cardiovascular	☐	☐	Neurological
☐	☐	Respiratory	☐	☐	Lymphatic / Blood	☐	☐	Endocrine	☐	☐	Eyes
☐	☐	Genitourinary	☐	☐	Musculoskeletal	☐	☐	Skin	☐	☐	Mental

If YES to any above, please explain: _____
_____

Current Medications:_____
Medication Allergies:_____
Do you use (Freq. & amount): ☐ Tobacco_____ ☐ Alcohol_____ ☐ Drugs_____
Recent Injuries, Surgeries, Hospitalization:_____

EYE HISTORY

Previous eye trauma, surgery, infection?_____
☐ Blurred vision ☐ Dry Eyes ☐ Stye ☐ Strabismus (eye turn) ☐ Amblyopia (lazy eye)
☐ Cataract ☐ Glaucoma ☐ Retinal hole/tear/detachment ☐ Macular Degeneration
☐ Eye allergy ☐ Conjunctivitis (pink eye) ☐ Other:_____
Do you wear: ☐ Glasses ☐ Contacts (type):_____

FAMILY HISTORY

Please note anyone in your family with a history of the following conditions:
☐ Diabetes_____ ☐ Hypertension_____
☐ Heart Disease_____ ☐ Cancer _____
☐ High Cholesterol_____ ☐ Autoimmune_____
☐ Cataract _____ ☐ Glaucoma _____
☐ Macular Degeneration_____ ☐ Retinal disease_____
☐ Strabismus_____ ☐ Amblyopia_____
☐ Other:_____

I hereby authorize the release of any medical information necessary to notify my family physician and/or process an insurance claim. I understand I am responsible for any charges not covered by my insurance.

Signature_____ Date_____

HOW DID YOU FIND US?_____

Dr. Review & Date_____