

Today's Date _____



WELCOME BACK TO OUR OFFICE

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home # ___ Work # ___ Cell # ___ Text ___ Email ___
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Date of Birth _____ Age _____
Sex M F

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

Dr Maureen Fahey and the Desert Valley Eye Care staff are committed to helping all their patients maintain good ocular health. We are here to keep you seeing well for the rest of your life by:

- *Providing the most comprehensive eye care available to each and every patient, focusing on their every need.*
- *Striving to maximize patient education, helping each patient understand all aspects of preventative eye health and vision care.*
- *Maintaining our luxurious optical with an exclusive selection that gives you style, variety and comfort.*

Insurance Information

Please note that insurance does NOT cover the Contact Lens Evaluation.

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes No

How will you settle your account today?

Cash Check Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- Blurry Vision
- Burning
- Cataracts
- Corneal Abrasions
- Crossed eye/Eye turn
- Double Vision
- Eye Infections
- Eye Injury
- Flash of light
- Floaters/Spots
- Glaucoma
- Grittiness
- Headaches
- Iritis/Uveitis
- Itchiness
- Lazy Eye
- Macular Degeneration
- Occasional dryness
- Retinal Detachment
- Sunlight Sensitivity
- Tearing
- Trouble seeing at night
- Uncomfortable glasses
- Other eye disorders _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Family Physician _____ Town _____ Date of Last Physical Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ _____		
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____		
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Hep C/HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
Medications you are taking can affect your vision and/or eye health: _____ _____		

Patient Eye History
Date of Last Eye Exam _____ By Whom? _____
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)
Relationship (Mother's or Father's side)
Blindness <input type="checkbox"/> _____
Cataracts <input type="checkbox"/> _____
Corneal Problems <input type="checkbox"/> _____
Diabetes <input type="checkbox"/> _____
Glaucoma <input type="checkbox"/> _____
Heart Disease <input type="checkbox"/> _____
Lazy Eye <input type="checkbox"/> _____
Macular Degeneration <input type="checkbox"/> _____
Retinal Problems <input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Desert Valley Eye Care.
If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits.
I acknowledge that I have read, or had the opportunity to read if I so chose, and understand the notice of Privacy Practices (NPP) and agree to its terms.
Signature _____