



Welcome to Carbon Valley Eye Care. Thank you for choosing us for your eye care needs.

We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following important information. If you have any questions, please do not hesitate to ask.

Patient Information:

Today's Date _____ / _____ / _____

Date of Birth _____ / _____ / _____

Name _____

Social Security Number _____ / _____ / _____

Address _____

Home Phone (_____) _____ - _____

Work Phone (_____) _____ - _____ Ext _____

Cell Phone (_____) _____ - _____

Email address: _____

Married Single Widowed Divorced

Gender: Male Female

Contact's Phone Number _____

Race _____

Emergency Contact: _____

Preferred Language _____

We prefer email as a means to notify our patients of their next appointment, annual recalls, as well as reminders that glasses or contact lenses are ready. Please check any additional preferred methods of contact:

Cell Phone Home Phone Work Phone Other _____

Employer: _____

Position: _____

Full-Time Part-Time Retired Student Not Employed

How did you hear about our office? Referral Advertisement Insurance Website Other _____

If you marked Referral please indicate: Family/Friend _____ Doctor _____

Name of Primary Care Physician: _____

Phone Number: _____

Address: _____

Date of last medical exam: _____

Vision Insurance Information: (Please present copy of card or we will be unable to bill on your behalf and payment will be your responsibility.)

VSP EyeMed VCP Vision Benefits via Medical Insurance Other _____

Medical Insurance Information: (Please present copy of card or we will be unable to bill on your behalf and payment will be your responsibility.)

United Healthcare Cigna Aetna Anthem/BCBS Medicare Humana Rocky Mountain Health

Sloans Lake/Cofinity Pacificare Great West Kaiser Other _____

Responsible Party's Name: _____ Date of Birth _____ / _____ / _____

Responsible Party's Employer: _____ Social Security Number _____ / _____ / _____

Eye and Vision History:

Main purpose of today's visit _____ Date of last Eye Exam: _____

Do you wear glasses? Yes No For What? Distance Near Computer Everything Sun

If yes, how old is your current pair? _____ Are they working? Yes No

Do you have problems with glare? Yes No Do you have problems with night driving? Yes No

Do you wear contact lenses? Yes No Are they comfortable? _____

What type of lenses? _____ Rigid Soft Extended Wear Disposable Bifocal Toric

How old is your current pair? _____ How often do you replace them? _____

Have you had any eye surgery? Yes No If yes, what type? _____ When? _____

Are you interested in finding out if you are a candidate for LASER refractive surgery (LASIK, PRK)? Yes No

Do you work on a computer? Yes No If yes, how many hours per day? _____ Distance to monitor _____”

Please make a check next to any problems you currently are experiencing or have experienced in the past:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Blurry distance vision | <input type="checkbox"/> Computer Eye Strain | <input type="checkbox"/> Halos | <input type="checkbox"/> Watery/teary eyes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Blurry near vision | <input type="checkbox"/> Light Flashes | <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Eye Irritation | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Pain/soreness | <input type="checkbox"/> Burning | <input type="checkbox"/> Trouble Focusing | <input type="checkbox"/> Redness | <input type="checkbox"/> Sandy/Gritty feeling |
| <input type="checkbox"/> Glare/reflections | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Sudden Vision loss | <input type="checkbox"/> Tired eyes | <input type="checkbox"/> Itching |

Medications and Allergies:

Please list any prescription or nonprescription medications you are taking, including eye drops, vitamins & herbal supplements and reason for taking them: None

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have allergies to any medications? Yes No List: _____

Do you suffer from seasonal allergies? Yes No List: _____

Medical History:

Please check conditions you or your immediate family have. Check all that apply and then to the side write (S) for Self, (M) Mother, (F) Father, (GP) Grandparent, (C) for Child, or (Sib) for Sibling.

Constitution

- Cancer
- Developmental Disability
- Fatigue Syndrome
- Other

Ears, Nose, Throat

- Hearing Loss
- Laryngitis
- Sinusitis
- Dry Mouth
- Other

Neurological

- Stroke/CVA
- Epilepsy
- Migraine
- Multiple Sclerosis
- Tumor
- Cerebral Palsy
- Other

Psychiatric

- Bipolar Disorder
- Attention Deficit
- Anxiety Disorder
- Depression
- Other

Cardiovascular

- Heart Disease
- Cong. Heart Failure
- Hypertension
- Vascular Disease
- Stroke/CVA
- Other

Respiratory

- Sleep Apnea
- Cigarette Smoker
- Emphysema
- Asthma
- Chronic Obstruction
- Bronchitis
- Other

Gastrointestinal

- Celiac Disease
- Crohn's
- Ulcer
- Colitis
- Acid Reflux
- Other

Genitourinary

- STD (herpetic, etc)
- Pregnant
- Herpes
- Prostate disease/cancer
- Benign Prostate Hypertrophy
- Nursing
- Kidney Disease
- Chlamydia

Musculoskeletal

- Fibromyalgia
- Ankylosing Spondylitis
- Gout
- Muscular Dystrophy
- Osteoporosis
- Arthritis
- Osteoarthritis
- Other

Integumentary (skin)

- Rosacea
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles
- Psoriasis
- Eczema
- Other

Endocrine

- Hormonal Disfunction
- Thyroid Disfunction
- Type 2 Diabetes
- Type 1 Diabetes
- Other

Hematologic/Lymph

- Large-volume blood loss
- Hypercholestermia
- Anemia
- Ulcer
- Other

Allergic/Immunologic

- Rheumatoid Arthritis
- Sjogren's Syndrome
- Drug Allergies
- Environmental Allergies
- Other

Eyes

- Nystagmus
- Retinal Detachment
- Cataract
- Inflammatory Disorder
- Retinal Degeneration/
Hole/Detachment
- Patching

- Macular Degeneration
- Glaucoma
- Injury
- Amblyopia
- Surgery
- Keratoconus
- Other: _____

- Dry Eye
- Glaucoma Suspect
- Strabismus

Lifestyle Questions:

Do you enjoy.... Computer Use Skiing/ Boarding Racquet Sports Running Fishing Woodwork
 Metal Work Hiking Hunting Motorcycling Golf Cycling Yoga/Dance Other _____

Do you drink? No Occasional 1 per day 2-3 per day 4+ per day

Do you smoke? Yes No If yes, how much per day? _____ If no, have you ever? _____