CLEAR VISION EYE CARE

VISION SOURCE

Dr. Andrew D. Bateman • Fallbrook Town Center

Tell us a little about yourself...

Date:_____

Name: _____ Employment Status: FT PT Other

Address: _____ Employer: _____

City, State, Zip: _____ Occupation: _____

Home Phone:_____ Spouse (or Parent) Name: _____

Daytime Phone: _____ Spouse (or Parent) Occupation: _____

Cell Phone:_____ Who may we thank for referring you to our office? _____

E-mail:_____ If not, how did you choose our office?

_____ Insurance List

Date of Birth: _____ _____ Saw Sign/Building

_____ Newspaper

Male/Female _____ Live/Work in the area

_____ Web Page: _____

SSN:_____-_____-_____ _____ Other _____

Marital Status: S M D W

Primary Insurance- Please Present Insurance Cards

Note: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage please contact your insurance company or HR department. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand the financial responsibility for your account is yours, not your insurance company's. I authorize the release of any medical records or other information necessary to process insurance claims. I authorize payments of medical benefits to the doctor. I understand payment is due when services are rendered or materials ordered.

Sign: _____ Date: _____

Medical Insurance Company: _____ ID #:_____

Vision Insurance Company: _____Insured's SSN: _____

Insured's Name: _____ Insured's DOB: _____

Address: _____ Patients Relationship to Insured:

_____ Self _____Spouse _____Child

Employer: _____

Last eye exam (MM/YYYY): _____ Dr. _____ Last Medical Exam: _____ Dr. _____
Reason for today's visit: _____
Do you wear glasses? ____No ____Yes, how old? _____ Prescription sunglasses? ____No ____Yes
Do you wear contact lenses? ____No ____Yes, type:_____ Solution:_____
Special Visual needs: (reading, computer, hobbies, etc.): _____
Do you have allergies to medications? ____No ____Yes, which? _____
List any medications you take: _____
List all major injuries/surgeries: _____
Do you use tobacco? ____No ____Yes Alcohol? ____No ____Yes

Review of Systems
Do you currently, or have you ever had any problems with the following areas:

System	NO	YES		System	NO	YES	
Constitutional				Ear, Nose, Mouth Throat			
Fever, Weight loss/gain, Fatigue	____	____		Allergies/Hay Fever	____	____	
Integumentary (skin)	____	____		Sinus Congestions	____	____	
Neurological				Runny Nose	____	____	
Headaches/Migraine	____	____		Post Nasal Drip		____	____
Seizures	____	____		Chronic Cough		____	____
Other	____	____		Dry Throat/Mouth	____	____	
Eyes				Respiratory			
Loss of Vision	____	____		Asthma		____	____
Blurred Vision	____	____		Chronic Bronchitis	____	____	
Distorted Vision/Halos		____	____	Emphysema		____	____
Loss of Side Vision	____	____		Cardiovascular			
Double Vision	____	____		Cholesterol	____	____	
Dryness	____	____		High Blood Pressure	____	____	
Mucous Discharge	____	____		Vascular Disease	____	____	
Redness	____	____		Gastrointestinal			
Glaucoma	____	____		Crohn's		____	____
Lazy eye	____	____		Ulcer	____	____	
Burning/Itching		____	____	Digestive		____	____
Foreign Body Sensation	____	____		Genitourinary			
Excess Tearing	____	____		STD	____	____	
Light Sensitivity	____	____		Kidney/bladder		____	____
Eye Pain/Soreness	____	____		Musculoskeletal			
Chronic Infection	____	____		Fibromyalgia	____	____	
Flashes/Floaters	____	____		Muscular dystrophy	____	____	
Tired Eyes	____	____		Arthritis	____	____	
Endocrine				Lymphatic/Hematologic			
Thyroid/other glands	____	____		Anemia		____	____
Type II Diabetes	____	____		Bleeding Problems	____	____	
Type I Diabetes		____	____	Immunologic		____	____

If yes/any other, please describe: _____

Family History

	NO	YES	Relationship		NO	YES	Relationship
Blindness	____	____	_____	Cancer		____	____
Cataract	____	____	_____	Diabetes		____	____
Glaucoma	____	____	_____	Hypertension		____	____
Macular Degen.	____	____	_____	Heart Disease		____	____
Retinal Problem	____	____	_____	Other		____	____

Lifestyle Questions..
Do you...

____ work at a computer? If yes, do you experience...

	Mild		Moderate		Severe	
Headaches during or after?	____		____		____	
Burning eyes?	____		____		____	
Blurred distance vision when looking up from the computer?		____		____		____
Dry, tired or sore eyes?		____		____		____
Squinting when looking at the computer?	____		____		____	
Neck/shoulder/back or overall body pain?	____		____		____	
Double vision?	____		____		____	
Letters running together on the screen?		____		____		____
Worse driving/night vision after?	____		____		____	
Halos around objects on the screen?	____		____		____	

____ Experience Dry eyes/ excessive tearing? If yes, Do you experience...

Light sensitivity?	____		____		____	
Eyes that feel gritty?	____		____		____	
Painful or sore eyes?	____		____		____	
Blurred vision?		____		____		____
Discomfort in windy conditions?	____		____		____	
Discomfort in air conditioned rooms?		____		____		____

____ Spend time outdoors? How much? _____ Hrs/week

____ Prefer not to wear glasses at times?

____ Interested in information on vision correction surgery?

____ Have more than one pair of current Rx eyewear?

____ Have family members in need of eye care?

If you have experienced any of these symptoms there are new lenses and technologies to combat many of the problems listed above. Please ask one of our trained and certified opticians for more details.