Broadway Vision Center

Today's Date ______________________

Patient Information

Last ______________________
First ______________________ MI ______________
Street ______________________
City ______________ State ______________
Zip Code ______________________
Date of Birth ______________ Age ________
Employer (or School) ______________________
Occupation (or Grade) ______________________
Sex M F
Preferred Language ❑English ❑Other ____________
Race ______________________
Ethnicity ______________________

Please fill out information
Phone Hm ______________ Wk ______________
Cell ______________________

Email address ______________________

Guarantor/Primary Insured Information (Responsible Party) Other Than Patient

Relationship of Guarantor/Primary Insured to Patient:

- Spouse
- Parent
- Other ______________________

Last Name ____________ First Name ____________
Address ______________________
City ______________ State ________ Zip ________
Home Phone ____________ Cell Phone ____________
Date of Birth ______________________
Employer Name ______________________
Employer Phone ______________________

Reason For Visit

What is the major purpose of this visit?

❑Exam
❑Blurred Vision
❑Broken Glasses
❑Floaters/Flashes
❑Other ______________________

____

Any problems with your current contact lenses or glasses?

____
____

WELCOME TO OUR OFFICE

Patient Medical History

Name of Family Physician ______________________
Address ______________________
Date of Last Physical Check-up ______________________
Current Height ______________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills. We would be happy to copy your list for you) ______________________
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? ______________________
____

Do you use cigarettes/tobacco? ❑Yes ❑ No

Do you consume alcohol? ❑Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

No Known Health Concerns ❑

"Vision For Living"

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

Patient Eye History

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______________________________

Approximate Date of Last Eye Exam________________
Last Seen By_____________________________________

Are you satisfied with the vision and comfort of your lined bifocal or progressive lenses? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_______________________________________
Solutions used____________________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑___________________________
Cataracts	❑___________________________
Corneal Problems	❑___________________________
Diabetes	❑___________________________
Glaucoma	❑___________________________
Heart Disease	❑___________________________
Lazy Eye	❑___________________________
Macular Degeneration	❑___________________________
Retinal Problems	❑___________________________

"Vision For Life"

Lifestyle History

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

- ❑..work at a computer more than 20 minutes at a time?
- ❑..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 an issue with brightness or glare?
- ❑..prefer not to wear your glasses at times?
- ❑..commute 10 plus miles one way?
- ❑..participate in any activity that puts your eyes at risk?

Who may we thank for referring you to our office?

Name of friend or relative ______________________

If not referred, how did you choose our office?

- ❑ Another Doctor suggested our office
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages: Which directory? ______________
- ❑ Web Page: Which Web Site? ________________
- ❑ Other _____________________________________

I acknowledge that I viewed/received a copy of the Broadway Vision Center notice of Privacy Practice.

Signature_______________________Date___________

I acknowledge that I viewed/received a copy of the Broadway Vision Center Financial Policy.

Signature_______________________Date___________