Welcome to Our Office!
Jessica Nisewonger, O.D., LLC

FAMILYVISIONCARE

Today's date_____

Patient Information

Mr. Mrs. Ms. Dr. **Patient Name:**			**Preferred Name:**
Address:	**City:**	**State:**	**Zip:**
Date of Birth:	**SSN:**		
Primary Care Doctor:	**City:**	**State:**	**Phone:**
If married, name of spouse:			
If under 18, name of parent or guardian:		**Relation:**	**Phone:**

Contact Information

Home Phone:	Work Phone:	Cell Phone:	Your e-mail address:

What is the best way for us to reach you? □ Home □ Work □ E-mail □ Cell

Insurance / Employer Information

Vision Insurance:	Medical Insurance:	Secondary Health Insurance (e.g., Medicare Supplement):
Policy Number:	Policy Holder Name:	Policy Holder DOB:
Your Employer:	Your Occupation:	

Referral

How did you learn about Family Vision Care?

□ Office Web site □ Other Web site □ Family/Friend □ Insurance List/ Website
□ Location/Sign □ Yellow Pages □ Doctor/School Referral

Lifestyle Questions

Do you participate in a flex spending account?
□ Yes □ No

Are you interested in applying for Care Credit?
□ Yes □ No

Do you have other prescription glasses?
□ Sunglasses □ Reading glasses
□ Sports glasses

□ Other:_____

Do you participate in any of the following hobbies or activities?

□ Golf □ Running
□ Reading □ Arts/Crafts
□ Biking □ Computer
□ Boating □ Sewing
□ Driving □ Fishing
□ Watch TV □ Hunting
□ Music
□ Water sports
□ Video games
□ Snow sports
□ Competitive sports

Which of the following visual demands do you encounter on a regular basis?

□ Reading
□ Computer work
□ Close-up work
□ Night Driving
□ Other

Contact Lenses

□ Not for me
□ I wear or desire contact lenses
□ I want to sleep in contact lenses
□ I want color contact lenses

Please turn this form over and complete Side Two

Medical History

Reason For Today's visit?

□ Annual Exam (no eye or vision problems) □ Blurred Distance Vision □ Blurred Near Vision

□ Other (explain): _____

Last Eye Doctor: **Last Eye Exam:** **Last Medical Exam:**

List all medications you take (prescriptions, over the counter, oral contraceptives, supplements):

Major injuries, surgeries, hospitalizations:

Allergies, including medicines that cause reactions or sensitivities:

Eye History

Strabismus (Crossed Eyes)	Y	N	Tired Eyes	Y	N	Color Blindness	Y	N
Amblyopia (Lazy Eye)	Y	N	Distorted Vision (Halos)	Y	N	Eye Pain or Soreness	Y	N
Glaucoma	Y	N	Glare/Light Sensitivity	Y	N	Foreign Body Sensation	Y	N
Cataracts	Y	N	Redness	Y	N	Infection of Eye or Lid	Y	N
Macular Degeneration	Y	N	Itching	Y	N	Mucous Discharge	Y	N
Retinal Detachment	Y	N	Burning	Y	N	Drooping Eyelid	Y	N
Headaches	Y	N	Excess Tearing/Watering	Y	N	Fluctuating Vision	Y	N
Blurred Distance Vision	Y	N	Dryness	Y	N	Loss of Vision	Y	N
Blurred Near Vision	Y	N	Sandy or Gritty Feeling	Y	N	Loss of Side Vision	Y	N
Double Vision	Y	N	Floaters	Y	N			

General Health Conditions

Neurological (MS)	Y	N	Stroke	Y	N	Anxiety or Depression	Y	N
Diabetes	Y	N	Blood/Lymph/Anemia	Y	N	Gastrointestinal	Y	N
Thyroid	Y	N	Cancer	Y	N	Ears, Nose, Throat	Y	N
Muscles, Bones, Joints/ Arthritis	Y	N	Weight Loss	Y	N	Skin	Y	N
Asthma/Emphysema	Y	N	Fever	Y	N	Sleep Apnea	Y	N
Cardiovascular (High Blood Pressure)	Y	N	Kidney	Y	N	Migraines	Y	N
Pregnant Due Date_____	Y	N	Nursing	Y	N			

Family History

Blindness	Y	N	Macular Degeneration	Y	N	Stroke	Y	N
Strabismus (Crossed Eyes)	Y	N	Retinal Detachment	Y	N	Thyroid Disease	Y	N
Amblyopia (Lazy Eye)	Y	N	Cancer	Y	N	Kidney Disease	Y	N
Glaucoma	Y	N	Diabetes	Y	N	Other:	Y	N
Cataracts	Y	N	High Blood Pressure	Y	N	_____		

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Please Check any of the following that you use: □ Tobacco Products □ Alcohol □ Illegal drugs/ other substances

If yes, please explain type and how long:

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis (□ A □ B □ C) □ HIV □ AIDS □ Syphilis