Welcome to

Rocky Mountain Optical, a Vision Source™ member

Name_____ Date_____/_____/_____

Gender: M F Other Birthdate_____/_____/_____ Email Address: _____

Phone: Home_____ Work_____ Cell_____

Address_____Apt/Unit_____ City_____ State _____ Zip _____

Employer (or school)_____ Occupation (or grade)_____

Person responsible for payment on account_____ Relationship to patient_____

Emergency contact name:_____ Emergency contact phone:_____

Reason for your visit today: (Circle all that apply)

Routine eye exam	Contact lens exam	Update glasses/contact lenses	Blurred vision	Infection
Diabetic eye exam	Glaucoma Consult	Eye pain/Redness/Discharge	Lasik evaluation	Flashes/floaters
Dry Eye	Other: Please explain _____			

Insurance

Vision Insurance: _____ Insured's Name _____

Member ID Number:_____ Insured's Birthdate_____/_____/_____

Insured's Address (if different)_____ City_____ State ____ Zip _____

Medical Insurance: _____ Insured's Name_____

Member ID Number:_____ Insured's Birthdate_____/_____/_____

Insured's Address (if different)_____ City_____ State ____ Zip _____

Health History Questionnaire

PLEASE LIST ANY CURRENT MEDICAL DIAGNOSES IN THE FOLLOWING CATEGORIES (for example: heart disease, diabetes, menopause, skin problems, arthritis, headaches, multiple sclerosis, anxiety/depression, asthma, etc), or mark "none"

Cardiovascular_____ None

Constitutional_____ None

Endocrine_____ None

Gastrointestinal_____None

Genitourinary_____ None

Integumentary_____ None

Musculoskeletal_____ None

Neurological_____ None

Psychiatric_____ None

Respiratory _____ None

PERSONAL OCULAR HISTORY:

Injuries, surgeries, and/or infections_____

_____

PERSONAL MEDICAL HISTORY:

Injuries, surgeries, and/or hospitalizations_____

_____

ALLERGIES OR DRUG HYPERSENSITIVITIES (including type of reaction)_____

_____

SYSTEMIC FAMILY HISTORY:

None Arthritis Cancer Diabetes Hypertension High Cholesterol Thyroid Disease

Other_____

OCULAR FAMILY HISTORY:

None Cataract Glaucoma Macular Degeneration Strabismus (Crossed) or Amblyopia (Lazy Eye)

Other_____

OCULAR MEDICATIONS: (including over-the-counter)_____

_____

SYSTEMIC MEDICATIONS: (including over-the-counter)_____

_____

SOCIAL HISTORY:

Use of alcohol? NO YES Type/Quantity/Frequency_____

Use of tobacco? NO YES Type/Quantity/Frequency_____

Use of narcotics? NO YES Type/Quantity/Frequency_____

Personal Review of Systems

CURRENT EYEWEAR STATUS:

Do you currently wear glasses? NO Distance Only Reading Only Computer Progressive Bifocal YES

CURRENT CONTACT LENS STATUS:

Do you currently wear contact lenses? NO YES Brand_____

Power: R_____ L_____ (include astigmatism, if applicable)

Additional Information

Please list any visual needs relating to your occupation, recreation, or hobbies_____

_____

How did you find out about our office?_____