The information in this confidential personal history form is critical to the evaluation of your vision

Today's Date____________________________

Name____ Age______ Date of Birth_____________________

Address____ City______________________ ZIP____________

Home Phone (_______)__________________________ Cell Phone (_______)_________________________

Social Security # _________ / ______ / ____________ Driver's License # _____________________________

Employer_____________________________________ Work Phone(_______)________________ Ext. ______

Person Responsible for account ____________________

Date of your last eye examination_______________ Have you ever had vision therapy? ❑ Yes ❑ No

Have you ever worn glasses? ❑Yes ❑No Do you wear glasses now? ❑ Yes ❑No

If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer monitor ❑ sports

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today? ____

____

Are there times when your vision (or present lens) isn't quite right? ___________________________

____

Are there any activities you would enjoy doing, but must restrict because of your vision? _________

____

Are you interested in vision improvement? ❑ Refractive Surgery ❑ Laser Correction ❑ Non-Surgical

Allergies	❑Self	❑ Family
Respiratory disease	❑Self	❑ Family
Cancer	❑Self	❑ Family
Diabetes	❑Self	❑ Family
Drug sensitive	❑Self	❑ Family
Elevated cholesterol	❑Self	❑ Family
Heart problem	❑Self	❑ Family
High blood pressure	❑Self	❑ Family
Thyroid	❑Self	❑ Family
Migraine or headaches	❑Self	❑ Family
Head trauma	❑Self	
Lazy eye	❑ Self	❑ Family
Turned eye	❑ Self	❑ Family
Color "blind"	❑ Self	❑ Family
Light sensitive	❑ Self	❑ Family
Eyestrain	❑ Self	❑ Family
Dry eyes	❑ Self	❑ Family
Floaters/spots	❑ Self	❑ Family
Flashing lights	❑ Self	❑ Family
Retinal detachment	❑ Self	❑ Family
Blindness	❑ Self	❑ Family
Cataracts	❑ Self	❑ Family
Glaucoma	❑ Self	❑ Family
Eye surgery or injury ______________________________		

Are you currently under a physician's care? ❑No ❑ Yes Dr.'s name? _______________________

Are you regularly taking medications? ❑No ❑ Yes Date of last physical ____________

For what conditions? 1________________ 2_______________ 3________________ 4________________

How is your general health? (circle one) Excellent Good Fair Poor

VERY IMPORTANT! ***NEW PATIENTS:*** *WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

*Name of friend or relative*____

If not referred, how did you choose our office for your visual needs? Please check the appropriate answer:

❑ Relative ❑ Another Dr. ❑ Yellow Pages ❑ on-line from____________________________

❑ Friend ❑ Insurance List ❑ Saw Sign/Building ❑Other_______________________________

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Please fill in both sides of this form as completely as possible

Do you wear contact lenses at this time? ❑Yes ❑No What type? ________________________________

Have you had problems wearing contacts?❑Yes ❑No Describe ________________________________

Have you been told you cannot wear them?❑Yes ❑No Are you interested in trying contacts? ❑Yes ❑No

OCCUPATION: What kind of work do you do?____

What activities do you do at work: ***(Circle all that apply)*** driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.

Other activities: ____

Do you use a computer on your job? . . . . ❑ **Yes** ❑ **No** # hours daily _________

Do you use a computer at home? . . . . . . ❑ **Yes** ❑ **No** # hours daily _________

What lenses do you wear? . . . . ❑ **None** ❑ **glasses** ❑ **bifocals** ❑ **contacts**

When computing, do your eyes get . . . . ❑ **red** ❑ **dry** ❑ **ache** ❑ **Sore**

Do you feel pain or discomfort in your. . . ❑ **neck** ❑ **back** ❑ **shoulder**

Do letters ever seem to "swim"? . . . . ❑ **Yes** ❑ **No**

Does office lighting bother you? . . . . ❑ **Yes** ❑ **No**

Do reflections and glare bother you? . . . ❑ **Yes** ❑ **No**

Is it hard to proof-read, or find errors?. . . ❑ **Yes** ❑ **No**

Do you experience any of the following discomforts at work or at home?

❑ Headaches? ❑ Letters blur as you read? ❑ Occasionally see double?

❑ Eyestrain? ❑ Eyes red or watery? ❑ Pulling sensation near eyes?

❑ Get sleepy? ❑ Lose your place often? ❑ Do you avoid certain tasks?

❑ Does it take more and more effort to see clearly as the day wears on?

❑ Do you avoid reading after work, but read on weekends? How long can you read?_______________

❑ Do you "hunch" closer to your work as the day wears on?

❑ Do street signs ever seem blurred as you drive home from work?

❑ Is it ever difficult to bring print or objects to clear focus? When________________________________

RECREATION AND LEISURE:

In what recreational activities do you participate? (*Circle* all that apply) read racquetball tennis golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities____

Do you wear any special or protective eyewear for your sport? ❑ **Yes** ❑ **No**

Does your vision, or do your lenses, interfere with any activity? ❑ **Yes** ❑ **No**

What are you doing to protect your eyes from ultraviolet exposure?_____________________

Do you currently wear glasses that have an anti-reflective coating? ❑ **Yes** ❑ **No**

Television: is viewing ever uncomfortable? Please describe your discomfort:________________

____

Do you recline while viewing? ❑ **Yes** ❑ **No** **D**o your lenses work for TV? ❑**Yes** ❑ **No**

Do you often play video games? ❑ **Yes** ❑ **No** # of hours daily

PAYMENT TERMS: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, Visa and Mastercard. A monthly rebilling fee of $5 is added to all accounts with unpaid balances after 30 days.

I have read and agree to all the provisions of the office financial policy

I have received/reviewed a copy of the health care information privacy policy for Simpson and Mann Optometry

Signed ____ Date ______________________________