Welcome to Village Eyes Optometry

Date___________

Jon D. Vogel, O.D. Associates: Annie Hu, O.D.
Lorin E. Vogel, O.D. Babareh Golbahar, O.D.
Donna Weiss, O.D.

PERSONAL INFORMATION

LAST NAME	FIRST NAME	MI
ADDRESS	CITY	STATE ZIP
BIRTHDAY	REFERRED BY:	

INSURANCE INFORMATION

VISION INSURANCE		SUBSCRIBER'S NAME
SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S EMPLOYER
MEDICAL INSURANCE		SUBSCRIBER'S NAME
SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S EMPLOYER

HEALTH HISTORY

Date of Last Physical ______________ Name of Physician ______________

Do You Currently Have Or Had Any Of The Following Conditions?

❑Diabetes ❑ Respiratory Problems ❑ Cancer
❑Hypertension ❑ Stroke/Neurological ❑ Kidney Problems
❑High Cholesterol ❑ Cardiovascular Problems ❑ Skin Disorders
❑Thyroid Problem ❑ Blood Clot/Bleeding ❑ Are You Pregnant?
❑Anxiety/Depression ❑ Sickle Cell/Anemia ❑ HIV/AIDS
❑Hepatitis ❑ Tuberculosis ❑ Arthritis
❑Other (Please Explain ______________

Date of Last Eye Exam ______________ Name of Eye Doctor ______________

Have You Ever Been Treated For Or Diagnosed With Any Of The Following?

❑Cataracts ❑ Glaucoma ❑ Eye Infection
❑Amblyopia/Lazy Eye ❑ Macular Degeneration ❑ Eye Surgery
❑Strabismus/Crossed Eye ❑ Retinal Problems ❑ Eye Trauma

Do You Experience Any Of The Following?

❑Blurred Vision ❑ Burning ❑ Flashes of Light
❑Double Vision ❑ Itching ❑ Floaters
❑Dryness ❑ Tearing ❑ Eye Pain
❑Light Sensitivity ❑ Redness ❑ Unexplained Headaches

Do You Have A Family History Of The Following?

❑Diabetes ❑ Glaucoma ❑ Retinal Detachment
❑Hypertension ❑ Amblyopia/Lazy Eye ❑ Strabismus/Crossed Eyes
❑Blindness ❑ Macular Degeneration ❑ Cataracts

LIST MEDICATIONS:	LIST ALLERGIES:

CONTACT INFORMATION

Home Phone: ______________

Work Phone: ______________

Cell Phone: ______________

***Email:** ______________

What is the best way for us to reach you?
❑Home ❑Work ❑Cell ❑Email

*Please enter your e-mail address if you would like to receive special offers and product information via electronic mail. You can unsubscribe from e-mail communications you receive from us at anytime. The mailing list is private and will not be sold.

Do you participate in a Flex Spending Account ❑ Yes ❑ No

Are you interested in applying for Care Credit ❑ Yes ❑ No

How do you plan to settle your account today? ❑ Cash ❑ Check ❑ Credit

Do you have an AARP Card? ❑ Yes ❑ No

LIFESTYLE QUESTIONS

➢ Which of the following visual demands do you encounter on a regular basis?
❑Artificial lighting ❑Computer work
❑Reading ❑Night Driving
❑Close-up work ❑Other ______

➢ Do you participate in any of the following hobbies or activities?
❑Golf ❑Running ❑Reading
❑Biking ❑Arts/Crafts ❑Computer
❑Boating ❑Water sports ❑Sewing
❑Hunting ❑Watch TV ❑Driving
❑Music ❑Snow sports ❑Fishing
❑Competitive sports ❑Video games

➢ Do your eyes seem bothered by glare from any of the following situations?
❑Car headlights ❑Computer monitor
❑Traffic lights ❑Fluorescent lights
❑Night driving ❑Sunshine
❑Bright Lights ❑Other

➢ Do you have other prescription glasses?
❑Sunglasses ❑Reading glasses
❑Sports glasses ❑Other ______

➢ What do you like about your current glasses or contacts? (color, style, fit, etc.)

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➢ What do you dislike about your current glasses? (weight, thickness, glare)

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