VISION MAX PATIENT HISTORY QUESTIONNAIRE

New Patient ☐ Previous Patient ☐ Vision Insurance Y/N/Kind:_____

Name:_____

Address:_____City:_____Zip:_____

Telephone (H):_____ (W):_____

SNN:_____ - _____ - _____ Date of Birth:_____- _____- _____

Occupation:_____ Employer:_____

Emergency Contact/Telephone Number: _____

Date of last eye exam: _____ Do you wear glasses: Y/N Contact Lenses: Y/N/Type: _____

Have you had any eye operations? Y/N/Type: _____ Date: _____

Have you had any eye injury? Y/N/Type: _____ Date: _____

Do you have Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N

Other eye problems? Y/N What kind? _____

MEDICAL INFORMATION

Do you have problems with any of the following? (Please circle all that apply)

Gastrointestinal	Y/N	Nervous System	Y/N	Mental Illness	Y/N	Ears/Nose/Throat	Y/N	Kidney	Y/N
Thyroid	Y/N	Heart	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N	Pregnant	Y/N
Hypertension	Y/N	Respiratory	Y/N	Allergic	Y/N	Immunologic	Y/N	Arthritis	Y/N

Other: _____

Diabetes: Y/N Type: _____Date of diagnosis: _____

Allergies: Y/N To what? _____Medication Allergy Y/N To what?_____

Other health problems_____

Current Medication (s)_____

Have you had any operations? Y/N_____When?_____

Do you use cigarettes/tobacco?_____Alcohol?_____Other substances?_____

Name of family doctor_____Date of last visit_____Date of last tetanus shot:_____

FAMILY HISTORY

High blood pressure Y/N Relation_____ Macular degeneration Y/N Relation_____

Diabetes Y/N Relation_____ Retinal detachment Y/N Relation_____

Glaucoma Y/N Relation_____ Cataracts Y/N Relation_____

Other eye condition(s) Y/N What kind?_____

IN ADDITION TO THE BASIC EXAM WE OFFER: Contact lens evaluation for $30, dilation for $15 and visual fields test for $20.

Please check those services desires and initial:

Contact Lens Eval.	_____	_____	_____	_____	_____	_____	_____	_____
Dilation.	_____	_____	_____	_____	_____	_____	_____	_____
Visual Field	_____	_____	_____	_____	_____	_____	_____	_____
Patient's Initials	_____	_____	_____	_____	_____	_____	_____	_____
Date	_____	_____	_____	_____	_____	_____	_____	_____
Doctor's Initials	_____	_____	_____	_____	_____	_____	_____	_____

****SEE BACK PAGE FOR MORE INFORMATION****

Welcome to Vision Max Optometry

Dr. Anderson, Dr. Hung and staff want this to be your best eye exam ever. To insure this, two additional tests may be performed.

1) Dilation is a procedure that allows the doctor a better look in the back of your eye. Special drops are used that cause your pupil to open wider. After dilation, you may experience some blurred vision and light sensitivity.
1) Dilatcion es un precedimiento que le permite al doctor verla parte tracera de su ojo con mejor claridad. Unas goats especiales son usadas para hacer que sus piplas se abran. Despues de la dilatacion, puede ser que usted exprimente vision borrosa y susceptibilidad a la luz.

2) We are pleased to be able to offer you a visual field testing with our state of the art automated visual field analyzer. This test is important in the early diagnosis of eye disease including glaucoma and damage to the optic nerve or visual pathway.
2) Nosotros estamos complacidos en ofrecerle un examen de su campo visual con nuestro analisador de campo visual automatico. Este examen es importante en el diagnostico temprano de la enfermemdad del glaucoma y danos al nervio optico o camino visual.

BREAKING NEWS ABOUT ORDINARY EYEGLASSES

They shatter surprisingly easily. A study shows that the force of a slow tennis ball was enough to damage most glass and plastic lenses. In fact, just one type held up: those made of polycarbonate plastic.

WARNINGS: Patients should be advised of the following warnings pertaining to contact lens wear.

- Problems with contact lenses and lens care products could result in serious injury to the eye. Eye problems, including corneal ulcers, can develop rapidly and lead to loss of vision.
- Daily wear lenses are not indicated for overnight wear, and patients should be instructed not to wear lenses while sleeping. Clinical studies have shown that the risk of serious adverse reactions is increased when these lenses are worn overnight.
- The risk of corneal ulcers has been shown to be greater for users of extended wear lenses. The risk increases with the number of days that the lenses are worn between removals. This risk can be reduced by carefully following directions for routine lens care, including cleaning of the contact lens.
- Studies have shown that contact lens wearers who are smokers have a higher incidence of adverse reactions than non-smokers.
- If patients experience eye discomfort, excessive tearing, vision changes, or redness of the eye, the patient should immediately remove lenses and promptly contact his/her eye care practitioner.
- Never rinse your soft contacts with water! Only use approved solutions.

SEEING EYE TO EYE

What if the glasses break or lenses get scratched? Within one year of purchase the frame will be repaired for $18 or, if defective, replaced for $35. If scratch coating was purchased, lenses will be replaced for ½ price with one year. If not, replacement will be at our regular price. What is one of my new contact lenses is torn? We are unable to return torn contacts for credit because the manufacturer will not extend the warranty to cover torn lenses. You can, however, purchase an optional service agreement for $25 which covers torn lenses among other things.

If you don't see as well or as comfortably with your new glasses and/or contact as you had expected, our doctor and staff will work with you to find the best solution to the problem. If it is necessary to re-check the prescription, that will be completed at no charge. If lenses need to be changed, that also will be completed at no charge. If in spite of our best efforts, your expectations have not been met, then within 30 days we will give you credit for the return of your glasses/contacts. We do not refund because of expenses involved in providing these lenses.

I authorize release of information needed for insurance claims, consulting doctors or filling prescriptions.

PLEASE SIGN:_____ DATE:_____