Welcome to

ECLIPSE VISION SOURCE

PERSONAL INFORMATION

Patient's Name:_____ Male ❑ Female ❑ Date of visit:_____

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:____/_____/_____ Social Security# _____ Spouse/parent:_____

Occupation:_____ Employer/School:_____

Hobbies/Sports:_____ Who may we thank for referring you? _____

CONTACT INFORMATION

Home phone:_____ Cell phone: _____

Work phone:_____ Email: _____

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

VISION INSURANCE *(for annual exams)*

Insurance company: _____ Member ID#: _____

Name of member: _____Member's SS#: _____

Member's date of birth:_____Relationship to patient: _____

Name of employer: _____ Group # (if applicable): _____

MEDICAL INSURANCE *(for medical problems such as red eyes, infections, cataracts, etc.)*

Insurance company: _____ Member ID#: _____

Name of member: _____ Member's SS#: _____

Member's date of birth: _____ Relationship to member: _____

Name of employer: _____ Group # (if applicable): _____

WHY ARE YOU HERE TODAY? _____

TELL US ABOUT YOUR EYES

When was your last eye exam? _____

Do you wear glasses? Yes ❑ No ❑

Are you planning on getting a pair of glasses today? Yes ❑ No ❑

Do you have problems with glare or reflections? Yes ❑ No ❑

Do you wear contacts? Yes ❑ No ❑

Do they get dry at least once a day? Yes ❑ No ❑

Do you spend a lot of time outdoors? Yes ❑ No ❑

Are your eyes sensitive to sunlight? Yes ❑ No ❑

Do you work on a computer? Yes ❑ No ❑

How many hours a day? _____

Are you interested in Laser Vision Correction? Yes ❑ No ❑

DO YOU HAVE ANY OF THESE EYE CONDITIONS?

Cataract	Yes ❑	No ❑	Macular degeneration	Yes ❑	No ❑
Glaucoma	Yes ❑	No ❑	Retinal detachment	Yes ❑	No ❑
Blindness	Yes ❑	No ❑	Turned/lazy eye	Yes ❑	No ❑
Eye injury	Yes ❑	No ❑	Flashes of light	Yes ❑	No ❑
Eye surgery	Yes ❑	No ❑	Floaters/spots	Yes ❑	No ❑
Redness	Yes ❑	No ❑	Watering	Yes ❑	No ❑
Double vision	Yes ❑	No ❑	Itching	Yes ❑	No ❑
Keratoconus	Yes ❑	No ❑	Diabetic Retinopathy	Yes ❑	No ❑
Blurred vision	Yes ❑	No ❑	Crossed eyes	Yes ❑	No ❑
Burning	Yes ❑	No ❑	Double vision	Yes ❑	No ❑
Dryness	Yes ❑	No ❑	Eye pain	Yes ❑	No ❑

Do any of your family members have any eye diseases? Yes ❑ No ❑
If yes: What condition? _____ Relation to you: _____

DO YOU HAVE PROBLEMS WITH ANY OF THESE MEDICAL CONDITIONS?

Heart	Yes ❑	No ❑	Respiratory/Asthma	Yes ❑	No ❑
Allergies	Yes ❑	No ❑	High Blood Pressure	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑	Ear/Nose/Throat	Yes ❑	No ❑
Arthritis	Yes ❑	No ❑	Blood/Lymph	Yes ❑	No ❑
Thyroid	Yes ❑	No ❑	Stomach/Colon	Yes ❑	No ❑
Headache	Yes ❑	No ❑	Mental depression	Yes ❑	No ❑
Cancer	Yes ❑	No ❑	Genital/kidney/bladder	Yes ❑	No ❑
Hepatitis	Yes ❑	No ❑	HIV / AIDS	Yes ❑	No ❑

Do any of your family members have any of the above medical conditions? Yes ❑ No ❑
If yes: What condition? _____ Relation to you: _____

List any prescription medications you are taking: _____

_____

List any allergies to medications you have: _____

_____

Do you use cigarettes / tobacco / alcohol / or other substances? _____

Patient/Parent Signature: _____ Date: _____

Information reviewed / updated:

Date: _____	Date: _____	Date: _____	Date: _____
Initials: _____	Initials: _____	Initials: _____	Initials: _____

Doctor signature: _____ *Date:* _____