



# MACADAM VISION

WELCOME TO OUR OFFICE

Dedicated to your vision for life

## PATIENT INFORMATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
(Last, First, Middle Initial)

Nickname \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Ms. \_\_\_\_\_ Miss. \_\_\_\_\_ Other \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Communication Info: Please Circle Preference  
Cell, Home, Work, Email, US Mail

Home ( ) \_\_\_\_\_ - \_\_\_\_\_

Work ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell ( ) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

The new Health Care Act requires we ask the following questions to be in accordance with "Meaningful Use" of Electronic Health Records. Meaningful Use: An incentive to improve the health of the nation by ensuring that patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care.

(You may enter "Decline to provide")

SSN \_\_\_\_\_

Marital Status \_\_\_\_\_

Primary Language \_\_\_\_\_

Special Needs \_\_\_\_\_

Race \_\_\_\_\_

Ethnicity (Hispanic/Latino) YES / NO

Mother's Maiden Name \_\_\_\_\_

Birth State \_\_\_\_\_

## NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

Yellow Pages  Insurance List

Signage

Internet: Insurance List

Our Website

Yellow Pages

Other \_\_\_\_\_

## INSURANCE INFORMATION

Vision Insurance Co. \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Ins. ID# \_\_\_\_\_

VSP Patients- last 4 digits of SSN: \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Ins. ID# or SSN: \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Person responsible for account:  Self

Other \_\_\_\_\_  
(Last, First, Middle Initial)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City/State/Zip)

\_\_\_\_\_  
(Phone Number)

Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian \_\_\_\_\_

Do you participate in a flex spending account?

Yes

No

Dr. Initials \_\_\_\_\_

## LIFESTYLE QUESTIONS

**Do you.....(check box if your answer is yes)**

- ..work at a computer?
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..have prescription sunwear?
- ..want information on Laser Vision Correction surgery?
- ..have interest in pharmaceutical grade supplements for eye health?
- ..have more than 1 pair of current Rx eyewear?
- ..have family members in need of eye care?
- ..have children?
- ..headaches...Mild? Moderate? Severe?

**What is the major purpose of this visit?**

\_\_\_\_\_

**Any problems with your current contact lenses or glasses?**

\_\_\_\_\_

**Do you suffer allergies? Y / N Allergic to:** \_\_\_\_\_

\_\_\_\_\_

**Medical Allergies? Y / N What happens?** \_\_\_\_\_

\_\_\_\_\_

## SOCIAL HISTORY

Drug Abuse: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes: Name of drug \_\_\_\_\_

Alcohol Use: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes: # of drinks per week \_\_\_\_\_

Tobacco Use: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes:  
Smoked for \_\_\_\_\_ years  
Packs per day \_\_\_\_\_

Hobbies \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

## FAMILY MEDICAL/EYE HISTORY

I have been diagnosed with: (check those that apply)

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Macular Degen</li> <li><input type="checkbox"/> Eye Injury</li> <li><input type="checkbox"/> Retinal Disease</li> <li><input type="checkbox"/> Other Diseases</li> <li><input type="checkbox"/> Blindness</li> <li><input type="checkbox"/> Strabismus</li> <li><input type="checkbox"/> Amblyopia</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Dry Eye</li> <li><input type="checkbox"/> Other</li> <li><input type="checkbox"/> Other</li> </ul> | <p>Do you have a family history of:<br/>(Please list the relationship of the family member to you)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> </ul> |
|---|---|

## PATIENT MEDICAL HISTORY

Please list all medications that you are taking:  
(include eye drops, birth control, supplements)

\_\_\_\_\_

**Would you consider your overall health good? Y / N**

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Immune	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

**Are you Diabetic? Y / N Type I, Type II (non-insulin dependent)**

Surgical History Procedures and Dates: \_\_\_\_\_

\_\_\_\_\_

## Personal Eye Health History

	Yes	No
Have you had any eye surgeries?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any eye injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have..... blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>
other eye problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Date of Last Eye Exam _____ By Whom? _____		
Were your eyes dilated? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No <input type="checkbox"/> ..Can't remember		
Have you ever tried contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		
Do you currently wear contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		
What kind? _____ Solutions used _____		
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

*We are dedicated to improving our patients' quality of life by providing a clinical experience that invokes a sense of caring expertise memorable to the point of enthusiastic comment.*

Dr. Initials \_\_\_\_\_