

Blue Springs *Optical*

For a Lifetime of Healthy Vision

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WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name _____
Street _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Social Security Number _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ Age _____ Sex: M/F _____
E-Mail _____
What is your Marital Status? M ___ S ___ D ___ W ___

MEDICAL HISTORY

Allergies	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Skin Disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye Diseases	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye Injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pres	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye Surgery	<input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes
Lazy Eye	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nerve Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cataracts	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other	<input type="checkbox"/> No <input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes		

CURRENT MEDICATIONS

Please list all of your medications

(Including non-prescription medications, vitamins, and supplements.)

Who is your physician? _____

FAMILY MEDICAL HISTORY

RELATIONSHIP

Macular Degeneration	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cataracts	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Date of Last Exam _____ Date _____

What specific problems are you having with your eyes, vision, glasses, and /or contact lenses?

Spouse (or Parent) Name _____

Spouse (or Parent) Work Phone _____

Vision Insurance _____

Do you have a flexible spending account or cafeteria plan at your work? Yes No

How will you settle your account today?

Check Cash Credit/Debit Card

Do you . . .

..Have a spare pair of glasses? Yes No
..Have prescription sunglasses? Yes No
..Have problems with glare or reflections from your glasses? (particularly when driving at night) Yes No
..Want information on thinner/lighter lenses? Yes No
..Spend a lot of time outdoors? Yes No
..Wear lined bifocals or trifocals? Yes No
..If yes, are you interested in trying progressive/ no line lenses? Yes No
..Have family members in need of eye care? Yes No

Have you ever worn / are you currently wearing contacts?
 Yes No

What kind? _____ Solutions used _____

Are you interested in . . .

..Contact Lenses? Yes No
..Refractive Surgery? Yes No

Do you experience . . .

<input type="checkbox"/> Blurry distance vision	<input type="checkbox"/> Burning
<input type="checkbox"/> Blurry near vision	<input type="checkbox"/> Itching
<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Watery
<input type="checkbox"/> Reading problems	<input type="checkbox"/> Dryness
<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Redness
<input type="checkbox"/> Glare or reflections	<input type="checkbox"/> Sudden loss of vision
<input type="checkbox"/> Uncomfortable glasses	<input type="checkbox"/> Objects floating in vision
<input type="checkbox"/> Uncomfortable contact lenses	<input type="checkbox"/> Light Flashes
<input type="checkbox"/> Gritty feeling in eyes	<input type="checkbox"/> Eyestrain
<input type="checkbox"/> Headaches	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Other: _____	

How did you first hear about our office?

Friend or Relative. Who? _____
 Another Health Care Provider. Who? _____
 Yellow Pages. Which Directory? _____
 Print Advertisement. _____
 Radio / TV. Which station? _____
 Previous Patient. Who? _____
 Other _____