Family Eye Health MIAMI
MEMBER Vision Source NETWORK

WELCOME BACK!

Name ____ Home Phone ________________________

Address ____ Work Phone ________________________

City ________________ State _____ Zip __________ Cell Phone__________________________

Social Security # _________-________-__________ Date of Birth ________________________

If a child, parent's full name __________________________ ___ E-mail Address ______________________

Insurance Company ___________________________________ Policy # ____________________________

Do You…

- Work at a computer?
- Think you might benefit from thinner, lighter lenses?
- Have an interest to trial the latest contact lens designs?
- Spend time outdoors? If so, __________hours/week
- Have prescription sunglasses?
- Prefer not to wear your glasses at times?
- Want information on Laser Vision Correction surgery?
- Have interest in a non-surgical approach to vision correction?
- Have more than one pair of current prescription glasses?
- Have children?
- Have family members in need of eye care?
- Wear bifocals? ____ If so, do the lines or head tilting bother you? ____
- Wear contact lenses? ____ If so, are you satisfied with the vision and comfort? ____
- Prefer clear or colored contact lenses? _________

Have you ever been diagnosed or treated for the following?

- ☐ Cataracts
- ☐ Corneal Abrasion
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Iritis/Uveitis
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Lazy Eye
- ☐ Other Eye Disorders ________________ ________________

Have you ever been diagnosed or treated for the following?

- ☐ Allergies
- ☐ Cholesterol
- ☐ Cancer
- ☐ Thyroid
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Nerves
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney
- ☐ Other _____________

Do you experience or have ever experienced?

- ☐ Blurry Vision
- ☐ Tearing
- ☐ Headaches
- ☐ Double Vision
- ☐ Burning
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Dryness
- ☐ Sunlight Sensitivity
- ☐ Cross Eye/ Eye Turn
- ☐ Trouble seeing at night
- ☐ Flashes of Light
- ☐ Itchiness
- ☐ Uncomfortable Glasses

Current Medications (Prescribed or over-the-counter) – Please include eye drops, vitamins, & birth control pills.

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Allergies to Medications ____

*****Please be aware that when the exam is being performed, if a medical diagnosis is found, we may have to use your medical insurance due to the fact that your vision insurance will not cover these additional services*****

I have had the opportunity to review your Privacy Policy, effective 07/01/2017

Patient Signature X____ Date ____________