

Patient Name (Print): _____ DOB ____/____/____ Email: _____
 Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____
 Primary Care Physician: _____ Occupation: _____ Gender: M / F

Due to current Federal Medical Guidelines, we are required to obtain the following information

Preferred Language: English / Spanish **Preferred Communication Preference:** Email / Postal Mail / Telephone
Race: Black/African American, American Indian/Alaska Native, Hispanic, Asian, White, Native Hawaiian/Other Pacific Islander
Ethnicity: Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Not Hispanic or Latino

What is the main reason for your visit today? _____ **Do you wear?** Contacts / Eyeglasses **Are you interested in contacts?** Y / N

Medical/Family History

Please list current medications: _____

List any allergic reactions to **medications or eye drops:** _____

Women – Are you pregnant? Y / N

Please indicate if any of the conditions apply:

| Disease/Condition | Yourself | | | Family Member | | Relationship (Blood Relatives Only) |
|----------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-------------------------------------|
| | Yes | No | | Yes | No | |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | Blindness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye Turn | <input type="checkbox"/> | <input type="checkbox"/> | Eye Turn | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> | Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye Surgery | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Eye Injury | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Other: | | | | | | |

Are you diabetic? Y/N If so, what year were you diagnosed? _____ What was your blood sugar today? _____
 What is your most current HbA1C? _____

Review of Systems

Please indicate below (circle) if you have any of the following conditions:

Social Tobacco Use: Current Smoker / Former Smoker / Non-Smoker Non-prescription drugs Alcohol Consumption

Allergic/Immunologic

Lupus (SLE)
 Rheumatoid Arthritis
 Environmental Allergies
 Seasonal Allergies
 Other (i.e., Latex)

Ear, Nose and Throat

Sinusitis
 Upper Respiratory
 Tract Infection
 Other

Gastrointestinal

Crohn's Disease
 Colitis
 Acid Reflux/Ulcer
 Other

Skin/Integumentary

Eczema
 Rosacea
 Psoriasis
 Other

Psychiatric

Depression
 Bi-Polar
 Schizophrenia
 Other

Cardiovascular

High Blood Pressure
 Heart Disease
 Stroke
 Vascular Disease
 High Blood Cholesterol

Endocrine/Glands

Diabetes
 Hormone Dysfunction
 Thyroid Dysfunction
 Other

Respiratory

Asthma
 Bronchitis
 Emphysema
 Other

Muscle/Skeletal

Arthritis
 Fibromyalgia
 Ankylosing Spondylitis
 Other

Genital/Urinary

Urinary Tract
 Infection
 HIV Positive
 Herpes/Chlamydia
 Other

Hematologic/Lymphatic

Anemia
 Leukemia
 Bleeding Disorder
 Other

Neurological

Multiple Sclerosis
 Epilepsy
 Tremors
 Other

General Health

Weight loss/gain
 Fever
 Fatigue
 Trauma

Insurance Information: Are you covered by vision coverage? Y/N If yes, please list: _____

SSN/Insurance #: _____ Do you have secondary vision coverage? _____

At Heartland Vision we will make every effort to check your eligibility with your insurance carrier. Because of the ever-changing information with insurance companies and/or circumstances beyond our control, WE CANNOT GUARANTEE THAT YOUR VISION BENEFITS WILL ALWAYS COVER PART OR ALL OF YOUR PURCHASES FROM US. You will be responsible for any unpaid balance. If you have any concerns regarding your insurance benefits and eligibility, we urge you to contact your insurance carrier before you order products or services from us.

Lifestyle Information: To help us assist you with your eye care needs, please circle all that apply:

Boating/Fishing Computer use (give % of time each day _____) Shooting Golfing Motorcycling Bicycling
 Participate in Sports Swimming Driving Hunting Close-up work Woodworking Use of Power Tools
 Intermediate Work Gardening Reading Hiking Other: _____

Please sign to acknowledge this form is current and that you received a copy of Heartland Vision, Inc.'s Notice of Privacy Practices.

Patient's Signature or legal guardian : _____ Date: _____

Reviewed by Doctor's initials: _____

FOR OFFICE USE:

Eyeglasses 1: Date : _____

OD _____ Add: _____ Type: _____

OS _____ Add: _____ Material: _____
Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Eyeglasses 2: Date: _____

OD _____ Add: _____ Type: _____

OS _____ Add: _____ Material: _____
Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Contact Lenses:

Brand: _____ OD _____

BC: _____ OS _____

New Contact lens or trials

Brand: _____ OD _____

BC: _____ OS _____

Based on the patient's lifestyle, prescription and ocular health needs, what products do you recommend? (completed by Optometrist)

Teflon Coating / Prescription Sunglasses / Back-up pair of eyeglasses for contact lens wearers / Progressive No-Lines

Polarized / UV protection / Multiple Pair

Additional Notes:
