## Past Medical History

- ☐ Allergy
- ☐ Amblyopia
- ☐ Asthma
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Droopy Lid
- ☐ Ear
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney
- ☐ Lasik
- ☐ Macular Degen.
- ☐ Melanoma
- ☐ Migraine
- ☐ MS
- ☐ Respiratory
- ☐ Sinusitis
- ☐ Stye
- ☐ Thyroid
- ☐ Other...

## Social History

- ☐ Computer
- ☐ Reading
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ Fishing
- ☐ Tennis
- ☐ Swim
- ☐ Bike
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ No alcohol or drug abuse
- ☐ Other...

## Current Medicines

**Amount**

## Eye wear History

- ☐ Glasses
- ☐ Bifocals
- ☐ Trifocals
- ☐ No- line
- ☐ Soft Contacts
- ☐ Toric Soft
- ☐ Gas Perm
- ☐ Hard
- ☐ Monovision
- ☐ Disposable
- ☐ Overnight wear

**Mark box if yes.**

- ☐ Have you tried contact lenses?
- ☐ Not satisfied with the vision comfort of contacts?
- ☐ Would you prefer colored contacts?
- ☐ Do the bifocal's lines and head tilting bother you?

## Family History

- ☐ Blindness
- ☐ Cancer
- ☐ Crossed Eyes
- ☐ Color Blind
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Kidney
- ☐ Macular Degen.
- ☐ Retina Detach
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Thyroid
- ☐ Glaucoma
- ☐ None
- ☐ Other...

## Drug Allergies

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Eye drops
- ☐ Other...

## Lifestyle Questions

Do you...(Check box if your answer is yes)

- ☐ Work at a computer often?
- ☐ Think you might benefit from thinner lenses?
- ☐ Would like to "test drive" the latest contact lenses?
- ☐ Spend time outdoors?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want info. on Laser Vision Correction surgery?
- ☐ Have more than 1 pair of current Rx eyewear?

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** We charge $2.00 every month on balances over 60 days. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy.

*I have received a copy of The Vision Place" Notice of Privacy Practices".*

Remind me of my appointment by: ☐ Text

Signature _____ Date _____

Relationship to Patient: _____

Printed:

**Guardian:** **Date:**

**Name:**

**Address:**

**City, St:** **Zip:**

**Phone(H):** W: C:

**Date of Birth:** **Sex:** M

**E-Mail:**

**Occupation:**

**Notify me by:** ☐ Text ☐ Phone ☐ Email ☐ Mail

**Who may we thank for referring you to our office?**

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

**Emergency Contact Name and Phone:**

**Approx. Date of Last Eye Exam:**

## What is the major purpose of this visit:

☐ Blur at Far
☐ Blur at Near
☐ Blur at Far & Near
☐ Itching
☐ Burning
☐ Redness
☐ Eye pain
☐ Eye strain
☐ Flashes/Floaters
☐ Loss of vision
☐ Double vision
☐ Sandy/Gritty
☐ Spots or shadows
☐ Diabetes eye check
☐ Medical eye check
☐ Other...

**Which Eye?** ☐ Right eye ☐ Left ☐ Both eyes

**How long has it bothered you?**

☐ Started today ☐ 1-2 weeks ☐ 3-6 months
☐ 1-2 days ☐ 2-4 weeks ☐ Over 6 months
☐ 3-7 days ☐ 1-3 months

**Severity?** ☐ Mild ☐ Moderate ☐ Severe

**Getting Worse?**

☐ Getting better ☐ Getting worse ☐ About the same

## Current Prescription:

Glasses: Right
Left

Contacts: Right
Left

## Medical Doctor(s):

THEVISIONPLACE


**The Vision Place**
**Sandra P. Palomino, OD, PA**
**16535 HUEBNER RD. STE 104**
**San Antonio, Texas 78248**
**210-764-1113**


**Race**
American Indian or Alaska
Asian
Black or African-
Native Hawaiian or Other Pacific
Other
Unknown/undetermine
White

**Ethnicity**
Not Hispanic or Latino 2186-5
Hispanic or Latino 2135-2

**Language** ☐ English ☐ French ☐ Mandarin ☐ Other...
☐ Spanish ☐ Japanes ☐ Unknown

**Smoking**
○ Ex-smoker
○ Heavy tobacco smoker
○ Light tobacco smoker
○ Never smoked tobacco
○ Tobacco Smoking Consumption unknown

**Please note that insurance does NOT cover the Contact Lens Fitting Evaluation**

## Vision or Primary Insurance

**Ins. Name:**

**Ins Number:**

**Relationship:**

**Insured:**

**Insured DOB:** **Ins. Sex:** ○ M ○ F

**Co-pay:** **Materials:** ○ Y ○ N

## Medical or Secondary Insurance

**Ins. Name:**

**Ins Number:**

**Relationship:**

**Insured:**

**Insured DOB:** **Ins. Sex:** ○ M ○ F

**Co-pay:** **Materials:** ○ Y ○ N

**Participate in a flex spending account?** ☐ Y ☐ N