## VISION PLUS HEALTH QUESTIONARE

PATIEN	NT NAME:				DATE:		
PRIMA							
PATIENT SOCIAL SECURITY NUMBER:				EMERGENCY CONTACT:			
EMERO	GENCY CONTACT PE	HONE NUMBER:	·		RELATIONSHIP:		
			HOW DID YO	OU HEAR ABOUT	US?		
INTERI	NET SEARCH	OUR W	'EBSITE	RADIO	NEWSPAPAER		
REFER	RED BY FRIEND/FAI	MILY				· · · · · · · · · · · · · · · · · · ·	
DO NO	II WEAD OLAGEGO				DE THEM		
DO YOU WEAR CONTACT LENSES?							
HOW OLD ARE THEY?			WHAT BRAND ARE THEY?				
HOW C	OLD ARE THEY?						
DO YO	U WANT TO BE FIT V	WITH CONTACT	Γ LENSES TODAY?				
DO YO	U WANT TO BE FIT V	WITH CONTACT	Γ LENSES TODAY?				
DO YO	U WANT TO BE FIT V	WITH CONTACT	Γ LENSES TODAY?				
DO YO	OU WANT TO BE FIT VOU HAVING PROBLE	WITH CONTACT	r LENSES TODAY? R VISION, YOUR GLA	SSES OR YOUR CO	NTACT LENSES? PLEAS	SE EXPLAIN:	
DO YO	OU WANT TO BE FIT VOU HAVING PROBLE	WITH CONTACT	r LENSES TODAY? R VISION, YOUR GLA	SSES OR YOUR CO		SE EXPLAIN:	
DO YO	OU WANT TO BE FIT VOU HAVING PROBLE	WITH CONTACT	r LENSES TODAY? R VISION, YOUR GLA	SSES OR YOUR CO	NTACT LENSES? PLEAS	SE EXPLAIN:	
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## **SOCIAL HISTORY**

DO YOU DRIVE? YES / NO DO YOU HAVE VISUAL DIFFICULTY WHILE DRIVING?								
DO YOU USE TABACCO PRODUCTS? YES / NO	DO YOU DRINK ALCOHOL? YES / NO	DO YOU USE ILLEGAL DRUGS?	YES / NO					
HAVE YOU EVER BEEN EXPOSED TO OR INFECT	TED WITH: HEPATITIS or HIV?							

SYSTEM			
CONSTITUTIONAL		EARS, NOSE, MOUTH, THROAT	
FEVER, WEIGHT LOSS/GAIN	Y / N	ALLERGIES/HAY FEVER	Y / N
INTEGUMENTARY (SKIN)	Y / N	SINUS CONGESTION	Y / N
NEUROLOGICAL		RUNNY NOSE	Y / N
HEADACHES	Y / N	POST-NASAL DRIP	Y / N
MIGRAINES	Y / N	CHRONIC COUGH	Y / N
SEIZURES	Y / N	DRY THROAT/MOUTH	Y / N
EYES		RESPIRATORY	
LOSS OF VISION	Y / N	ASTHMA	Y / N
BLURRED VISION	Y / N	CHRONIC BRONCHITIS	Y / N
DISTORTED VISION/HALOS	Y / N	EMPHYSEMA	Y / N
LOSS OF SIDE VISION	Y / N	VASCULAR/CARDIOVASCULAR	
DOUBLE VISION	Y / N	DIABETES	Y / N
DRYNESS	Y / N	HEART PAIN	Y / N
MUCOUS DISCHARGE	Y / N	HIGH BLOOD PRESSURE	Y / N
REDNESS	Y / N	VASCULAR DISEASE	Y / N
SANDY OR GITTY FEELING	Y / N	GASTROINTESTINAL	
ITCHING	Y / N	DIARRHEA	Y / N
BURNING	Y / N	CONSTIPATION	Y / N
FOREIGN BODY SENSATION	Y / N	GENITOURINARY	
EXCESS TEARING/WATERING	Y / N	GENITALS/KIDNEY/BLADDER	Y/N
GLARE/LIGHT SENSITIVITY	Y/N	BONES/JOINTS/MUSCLES	
EYE PAIN OR SORENESS	Y / N	RHEUMATOID ARTHRITIS	Y / N
CHRONIC INFECTION EYE/LID	Y/N	MUSCLE PAIN	Y / N
STIES OR CHALAZION	Y/N	JOINT PAIN	Y/N
FLASHES / FLOATERS IN VISION	Y / N	LYMPHATIC/HEMATOLOGIC	
TIRED EYES	Y / N	ANEMIA	Y / N
ENDOCRINE		BLEEDING PROBLEMS	Y / N
THYROID/OTHER GLANDS	Y / N	ALLERGIC/IMMUNOLOGIC	Y / N
		PSYCHIATRIC	Y/N
IF YOU ANSWERED YES TO ANY OF T	THE ABOVE O	OR HAVE A CONDITION NOT LISTED, PLEASE	
MEDICATIONS:		,	

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BE MADE ETHER TO ME OR ON MY BEHALF TO DR. SMITH OR ANY SERVICES FURNISHED ME BY THAT DOCTOR. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASETO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

LIFETIME PATIENT SIGNATURE	DATE	
DOCTOR SIGNATURE	DATE	