

BOURN VISION AND LEARNING CENTER

Welcome to our office!

Your physical health, occupation, hobbies, and lifestyle affect your eyes in many ways. Please answer the following questions to help Dr. Bourn and the staff better address your eye health and vision needs. Thank you!

Today's Date: _____

Patient Name: Mr. Ms. Miss Dr. _____ Nickname: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: Male Female Work Phone: _____

Guardian: _____ Social Security #: _____ E-mail: _____

Primary Care Physician: _____ Date of Last Physical/Exam: _____

Date of Last Eye Exam: _____ By Dr. _____

Occupation: _____ Employed By: _____

Please list any occupational vision requirements you may have: _____

Please list any hobbies/sports/recreational activities: _____

Whom may we thank for referring you to our office? _____

Reason for today's visit: Annual Exam Glasses Contacts Eye Health Referred Other _____

INSURANCE INFORMATION

| VISION INSURANCE INFORMATION |
|---------------------------------|
| Carrier _____ |
| Member Name _____ D.O.B. _____ |
| Member ID # _____ Group # _____ |

| MEDICAL INSURANCE INFORMATION |
|---------------------------------|
| Carrier _____ |
| Member Name _____ D.O.B. _____ |
| Member ID # _____ Group # _____ |

MEDICAL HISTORY

| MEDICATIONS AND ALLERGIES | |
|---|--|
| Please list <u>ALL</u> medications, including over-the-counter meds: _____ _____ _____ _____ | Please list <u>ANY</u> allergies (medication or environmental): _____ _____ _____ _____ |

Please list any ***major*** medical conditions: _____

If you are female, are you pregnant or nursing? Yes No

*******PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO*******

REVIEW OF SYSTEMS

Please circle any of the following medical conditions you may have:

| | | |
|---|--|---|
| EYES/OCULAR Loss of Vision Blurred Distance Vision Blurred Near Vision Distorted Vision/Halos Loss of Side Vision Double Vision Night Vision Problems Color Vision Problems Dryness Mucous Discharge Redness Sandy or Gritty Feeling Itching Burning Excess Tearing/Watering Glare/Light Sensitivity Eye Pain or Soreness Chronic Infection of Eye or Lid Sties/Chalazion Flashes/Floater in Vision Tired Eyes Other: _____ _____ _____ _____ | RESPIRATORY Asthma Chronic Bronchitis Emphysema VASCULAR/CARDIOVASCULAR Diabetes Heart/Chest Pain High Blood Pressure Vascular Disease GASTROINTESTINAL Diarrhea Constipation GENITOURINARY Kidney Stones Difficult/Painful Urination Incontinence BONES/JOINTS/MUSCLES Rheumatoid Arthritis Muscle Pain/Weakness Joint Pain/Weakness LYMPHATIC/HEMATOLOGIC Anemia Bleeding/Bruising Problem ALLERGIC/IMMUNOLOGIC Eczema Immunological Disease | CONSTITUTIONAL Fever Recent Weight Gain/Loss INTEGUMENTARY (SKIN) Rash/Itching New Moles/Growth NEUROLOGICAL Headaches Migraines Dizziness Seizures Numbness/Tingling Sensation ENDOCRINE Thyroid Problems Other Gland Problems EARS/NOSE/MOUTH/THROAT Allergies/Hay Fever Sinus Congestion Runny Nose Post-Nasal Drip Chronic Cough Dry Throat/Mouth PSYCHIATRIC Memory Loss/Confusion Nervousness/Panic Attacks Insomnia Depression |
|---|--|---|

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

| DISEASE/CONDITION | NO | YES | ? | RELATIONSHIP TO YOU |
|----------------------------|--------------------------|--------------------------|--------------------------|---------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Crossed Eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other: _____ | | | | |

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box.)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes: If yes, please describe:

Do you use tobacco products? No Yes If yes, type/amount/how long: _____

Do you drink alcohol? No Yes If yes, type/amount/how long: _____

Do you use illegal drugs? No Yes If yes, type/amount/how long: _____

This information has been reviewed by me and is complete and up to date. Sign and date once for each subsequent visit.

Signed _____ Date _____ Signed _____ Date _____

Signed _____ Date _____ Signed _____ Date _____