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 Heath ❑ Referred ❑ Other_____

INSURANCE INFORMATION

VISION INSURANCE INFORMATION	MEDICAL INSURANCE INFORMATION
Carrier_____	Carrier_____
Member Name_____ D.O.B_____	Member Name_____ D.O.B._____
Member ID #_____ Group #_____	Member ID #_____ Group #_____

MEDICAL HISTORY

MEDICATIONS AND ALLERGIES	
Please list ***ALL*** medications, including over-the-counter meds:	Please list ***ANY*** 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*******

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REVIEW OF SYSTEMS

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

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

SOCIAL HISTORY

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