LIFETIME VISION CARE, LLC

Name: _____

Date: _____

Occupation: _____

Address: _____

_____

Email: _____

Preferred Language: ☐ English/ ☐ Spanish/ ☐ Other_____

Race: ☐ Caucasian/ ☐ Hispanic-Latino/ ☐ Other_____

Ethnicity: ☐ Non-Hispanic / ☐ Hispanic-Latino

Family Doctor: _____

Pharmacy Preference: _____

Reason For Visit:_____

Rev 09/20/19

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO <u>YOU</u> (previous or current):

	Yes		Yes
<u>General</u>		<u>Gastrointestinal (digestive)</u>	
Cancer	☐	Colitis	☐
Headache	☐	Crohn's Disease	☐
<u>Ear/ Nose/ Throat</u>		Celiac Disease	☐
Sinus Condition	☐	<u>Musculoskeletal</u>	
Hearing Loss	☐	Fibromyalgia	☐
Dry Mouth	☐	Arthritis	☐
<u>Neurologic</u>		Muscular Dystrophy	☐
Migraines	☐	Gout	☐
Tumor	☐	<u>Integumentary (skin)</u>	
Epilepsy	☐	Rosacea	☐
Stroke	☐	Shingles (zoster)	☐
Multiple Sclerosis	☐	Psoriasis	☐
Cerebral Palsy	☐	Eczema	☐
<u>Psychologic</u>		Cold sores (simplex)	☐
ADD/ ADHD	☐	<u>Endocrinology</u>	
Depression	☐	Type 1 Diabetes	☐
Anxiety	☐	Type 2 Diabetes	☐
<u>Cardiovascular</u>		Thyroid Condition	☐
Heart Disease	☐	Hormone Disorder	☐
High Blood Pressure	☐	<u>Blood Disorders</u>	
Vascular Disease	☐	Anemia	☐
<u>Respiratory</u>		High Cholesterol	☐
Bronchitis	☐	<u>Allergic Conditions</u>	
Sleep Apnea	☐	Lupus	☐
Asthma	☐	Rheumatoid Arthritis	☐
Emphysema	☐	Sjogren's Syndrome	☐

<u>Females Only:</u> *Are you currently pregnant or nursing?* ☐ **YES** ☐ **NO**

LIST CURRENT MEDICATIONS: _____

LIST MEDICATION ALLERGIES: LATEX ALLERGY? ☐ YES ☐ NO

Do <u>YOU</u> have (or previously had) any of the following eye conditions:

☐ Cataract ☐ Glaucoma ☐ Macular degeneration ☐ Other: _____

Are you a smoker? ☐ YES ☐ NO ☐ Former Smoker ☐ Vape

Do you drink alcohol? ☐ YES ☐ NO

Height: _____/ Weight: _____

(For Staff Use)

Blood Pressure	Pulse	Date
_____/_____	_____	____/____/____
_____/_____	_____	____/____/____

PLEASE TURN OVER – COMPLETE BACK PAGE

Do you have (or previously had) a Concussion? ☐ **YES** ☐ **NO** **WHEN:** _____

Do you have (or previously had) any of the following. Please circle all that apply:

Double Vision, Light sensitivity, Dizziness, Visual fatigue, Balance issues, Reading/concentration issues, decreased spatial awareness, Headaches

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Does a <u>member of your family</u> (parents, grandparents, or siblings) have any of the following conditions (list who has the condition)?

Macular Degeneration: ☐ YES _____, ☐ NO

Cataract: ☐ YES _____, ☐ NO

Glaucoma: ☐ YES _____, ☐ NO

Other: _____

Thyroid Disease: ☐ YES _____, ☐ NO

Cancer: ☐ YES _____, ☐ NO

Diabetes: ☐ YES _____, ☐ NO

Hypertension: ☐ YES _____, ☐ NO

Do you wear contact lenses? ☐ YES ☐ NO ☐ Never worn, but interested

IF yes, DO you want to ***renew*** (expires in 1 year) your contact lens prescription, today? ☐ YES ☐ NO

IF yes, there will be a corneal health EVAL FEE (determined by the doctor, typically ranging from $25-$65)

Please initial and date acknowledging this fee.

Initials	Date
_____	____/____/____
_____	____/____/____

Patient Acknowledge Review of Information & Revisions, if needed

Initials	Date
_____	____/____/____
_____	____/____/____