HILLCREST FAMILY VISION

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Today's Date _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____
Date of Birth _____ Occupation _____ Employer _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Dilated? Yes/No Referred By _____
Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

eMail: OK TO TEXT : Yes NO

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No _____ Type _____ Date of diagnosis _____
Allergies to medication Yes/No Which? _____ Reactions? _____
Other health problems _____
Current medication(s) _____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation	_____	Macular degeneration	Yes/No	Relation	_____
Diabetes	Yes/No	Relation	_____	Retinal detachment	Yes/No	Relation	_____
Glaucoma	Yes/No	Relation	_____	Cataracts	Yes/No	Relation	_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____
Have you had any eye operations? Yes/No Type _____ Date _____
Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type	_____

Additional information _____

Doctor Use Only

Reviewed by _____ ❍ No changes Date _____
Reviewed by _____ ❍ No changes Date _____
Reviewed by _____ ❍ No changes Date _____

E-mail Address _____

Form of Payment

Cash ___
Check ___
Charge ___
Ins ___ Marital Status _____ Primary Insured _____
Employer of Insured _____ DOB of Insured _____

Signature on File for Insurance _____

I accept *FULL* responsibility for complete payment of my bill should my insurance not cover the procedure or materials.

Signature _____ Date___/___/___

Office Use Only

Duty to Warn _____ Recall Date __/___/___
DFE/POLY _____ PR/COMP _____
Refusal of Procedure _____

Recall

01 bifocal hard
02 bifocal soft
03 bifocal spec
04 ext wear
05 ext wr tint
06 gas perm
07 sv hard
08 sv soft
09 sv soft tint
10 sv specs
11 bf soft dsp
12 toric dsp
13 toric soft
14 trif soft
15 progressive bf
16 mono vision soft
17 mono vision GP
18 No rx
19 cl prog eval
20 refractive
21 disp
22 mecicare
23 rx only
24 resp.party
25 vt
26 to return

Diagnosis

01 amblyopia
02 aphakia
03 astigmatism
04 cataracts
05 diabetes
06 det retina
07 glaucoma
08 hyperopia
09 iritis
10 macular deg
11 myopia
12 No Rx
13 pathology corneal
14 foreign body
15 presbyopia
16 floaters
17 ocular hypertension
18 retinal vess. sheathing
19 HA
20 strabismus
21 pseudophakia
22 binoc-va disorder
23 monoocular
24 GPC
25 computer
26 conjunctivitis
27 lid disorder
28 vitreal detachment
29 emmertropia

Messages

CL/Rx Ready _____
Other _____
Dates _____
_____
_____