WELCOME TO KILLEEN

Vision Source™

Patient ID# _____ Date_____

PATIENT INFORMATION

	Last	First	M.I.
Patient Name:			
Social Security #:		Birthday:	
Gender: ❑ M ❑ F			
Height:	Weight:		
Address:			
City:	State:	Zip:	
Email:			
Patient Employer/School:			
Occupation:			

INSURANCE INFORMATION

Primary Member Name:
Primary's Birthday:
Relationship to Primary: Self / Spouse / Child / Other
Insurance Co.:
Group/SSN #:
Supplemental Insurance:
Primary Member Name:
Group/SSN #:

REASON FOR VISIT

❑Eye Exam
❑Contact Lens Examination
❑Office Visit
❑Emergency
❑Other:

PHONE NUMBERS

Home Phone:
Daytime:
Cell Phone:
IN CASE OF EMERGENCY, CONTACT
Name:
Relationship:
Daytime:

ELECTRONIC HEALTH RECORDS

Killeen Vision Source will be maintaining all patient data electronically. Government mandated electronic health records require completion of the following questions.

Primary Language:	❑ English	❑ Spanish	❑ Other
Race:	❑ White	❑ African-American	❑ Other
Ethnicity:	❑ Hispanic or Latino	❑ Non-Hispanic or Latino	❑ Other
Communication Preference:	❑ Email	❑ Postal	❑ Telephone
Do You Use Tobacco?	❑Yes	❑No	

CHIEF COMPLAINTS

Please place a mark on "Yes" or "No" to indicate if you have any of the following:

	Yes	No		Yes	No
Allergies: Ocular	❑	❑	Floaters	❑	❑
Blurred Vision, Distance	❑	❑	Foreign Body Sensation	❑	❑
Blurred Vision, Near	❑	❑	Glaucoma	❑	❑
Blurred Vision, Night Vision	❑	❑	Headaches/Migraine	❑	❑
Cataracts	❑	❑	Itching Eyes	❑	❑
Discharge from Eyes (Thick)	❑	❑	Loss of Vision	❑	❑
Discharge from Eyes (Watery)	❑	❑	Lumps/Lesions	❑	❑
Double Vision	❑	❑	Pain	❑	❑
Dry Eyes	❑	❑	Red Eyes	❑	❑
Eye Strain	❑	❑	Vision Field Loss	❑	❑
Flashes	❑	❑	Watering Eyes	❑	❑

PLEASE COMPLETE BOTH SIDES OF THE FORM OVER→

FAMILY HISTORY

Please place a mark on "Yes" or "No" and indicate which family member (maternal or paternal; parents, grandparents, siblings, children, living or deceased) have or had the following conditions:

OCULAR	Yes	No	Relationship
Blindness	❑	❑	_____M/P
Glaucoma	❑	❑	_____M/P
Cataracts	❑	❑	_____M/P
Retinal Detachment	❑	❑	_____M/P
Macular Degeneration	❑	❑	_____M/P

Other:_____

_____

SYSTEMIC	Yes	No	Relationship
Diabetes	❑	❑	_____M/P
Heart Disease	❑	❑	_____M/P
High Blood Pressure	❑	❑	_____M/P
Stroke	❑	❑	_____M/P
Cancer	❑	❑	_____M/P

*What kind?*_____

Thyroid Disease	❑	❑	_____M/P

REVIEW OF SYSTEMS

Do you have any problems in the following areas:

	Yes	No	?
ALLERGY			
Seasonal Allergies	❑	❑	❑
CARDIOVASCULAR			
Cardiovascular Disease	❑	❑	❑
Chest Pain	❑	❑	❑
Elevated Cholesterol	❑	❑	❑
Hypertension	❑	❑	❑
ENDOCRINE			
Diabetes 2 (Mellitus)	❑	❑	❑
Diabetes 1 (Insipidus)	❑	❑	❑
Thyroid Disorders	❑	❑	❑
MUCULOSKELETAL			
Arthritis	❑	❑	❑
Osteoporosis	❑	❑	❑

	Yes	No	?
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Stroke	❑	❑	❑
PSYCHIATRIC			
Anxiety Disorder	❑	❑	❑
Depression	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑

IF OTHERS, PLEASE LIST:_____

_____

MEDICATIONS

Please list any medications you take and how long you have been taking them (including prescription, over the counter, and eye medications) or attach a copy of a medication list

❑None

_____

_____

ALLERGIES TO MEDICATIONS

Do you have any allergies to medications? ❑Yes ❑No

If yes, please list any allergies you have to medications or other substances and your reactions:

_____

_____

AUTHORIZATION

The above questions were answered to the best of my knowledge. If I am signing as a parent/guardian, I authorize Killeen Eyecare Center to treat my child for any eye-related care. I agree to pay for any and all services/products at the time of this eye exam: if I do not have insurance, if my insurance is not valid during the period of authorization, or if my insurance is valid, but there is a difference that is owed.

X_____ _____ _____

Signature of Patient or Patient Representative | Date | Relationship of Patient Representative to Patient