

Hopkinton Vision Center

Name: _____
Date of birth: _____ Sex: _ M _ F
Address: _____
City/State/Zip: _____
Tel: H (_____) _____ W (_____) _____
Social Security # _____
E-Mail _____ @ _____

Primary Care Physician: _____

Reason for today's visit: _____

Who may we thank for referring you? _____

If you have a separate vision Plan from your Health Insurance , please Inform the Staff..

Health Assessment:

Do you have a history of the following health conditions?

Yes No (check the appropriate box)

- Diabetes
- High blood pressure
- Thyroid Condition
- Heart condition
- Lung condition
- Allergies
- Arthritis
- AIDS/HIV

Please list all your current medications:

Drug allergies: _____

Do you smoke? Yes ____ packs per day
No

Does anyone in your immediate family have a history of the following health conditions?

Yes No (check the appropriate box)

- Diabetes
- High blood pressure
- Glaucoma
- Thyroid condition
- Heart condition
- Lung condition
- Arthritis

Insurance Subscriber Information

Name _____
D.O.B. _____
Social Security # _____

Eye Assessment:

Have you ever had any of the following eye conditions?

Yes No (check the appropriate box)

- Turned eye or lazy eye
- Eye surgery (Including LASIK)
- Eye injury
- Floaters or spots in vision
- Flashes of light in vision
- Double vision
- Eyes burn, itch or water
- Eye infection
- Glaucoma

Do you currently wear glasses? Yes No
When do you wear your glasses? (Check all that apply)

- All the time
- Distance vision only
- Reading/near work only
- Computer work
- Work safety
- After contact lens wear

*****For Contact Len Wearers*****

Have you ever worn contact lenses? Yes No
Do you currently wear contact lenses? Yes No

If Known, Please list the type of contacts that you wear:

Do you work at a computer or video display terminal?
Yes No

What hobbies or sports do you participate in?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I also understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Signature of patient (or parent if minor) _____ Date _____