RANCH ROAD VISION SOURCE

Date: ____/_____/_____

Patient Information

Patient Name: _____ **Date of Birth:** _____/_____/_____
Last First MI

Address: _____ **Social Security #:** _____
Street

_____ **Home Phone:** _____
City State Zip

Email Address: _____ **Cell Phone:** _____

Employer/School: _____ **Occupation:** _____

Race: Caucasian | African American | Asian | American Indian | Other **Sex:** Male | Female

Ethnicity: Hispanic or Latino | Non-Hispanic or Latino **Language:** English | Spanish | Other

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Reason for Visit

Please check Yes/No if you are experiencing any of the following problems with your eyes:

	Yes	No		Yes	No
Allergies: Ocular	☐	☐	Flashes/floaters in vision	☐	☐
Blurred Vision, Distance	☐	☐	Haloes/Glare/Light Sensitivity	☐	☐
Blurred Vision, Near	☐	☐	Headaches/Migraines	☐	☐
Burning	☐	☐	Itching Eyes	☐	☐
Discharge	☐	☐	Loss of vision	☐	☐
Double Vision	☐	☐	Loss of side vision	☐	☐
Dryness	☐	☐	Lumps/lesions	☐	☐
Excess tearing/watering	☐	☐	Redness	☐	☐
Eye pain or soreness	☐	☐	Sandy or gritty feeling	☐	☐
Eye Strain	☐	☐	Other:_____	☐	☐

Medical History

Have you or an immediate family member been diagnosed with any of the following conditions:

	Self	Family	Relationship		Self	Family	Relationship
Blindness	☐	☐	_____	Cancer	☐	☐	_____
Cataracts	☐	☐	_____	Diabetes	☐	☐	_____
Dry Eye	☐	☐	_____	Heart Disease	☐	☐	_____
Glaucoma	☐	☐	_____	High Blood Pressure	☐	☐	_____
Lazy Eye	☐	☐	_____	Stroke/CVA	☐	☐	_____
Macular Degeneration	☐	☐	_____	Thyroid Disorder	☐	☐	_____
Retinal Disease	☐	☐	_____	Other:_____	☐	☐	_____
Other:_____	☐	☐	_____				

****OVER to complete both sides****

Primary Care Physician:_____ Date of Last Physical Exam: _____/_____/_____

Date of Last Eye Exam: _____/_____/_____

List all **medications** (prescription, over-the-counter, or eye medications) you are currently using: □ None

List all medication ALLERGIES □ None

List all major **surgeries** (including eye surgeries) and/or hospitalizations □ None

Review of Systems

Please check Yes/No if you are experiencing problems in any of the following areas:

	Yes	No		Yes	No
General: weight loss/gain, fever	□	□	Genitourinary: kidney, prostate, or bladder	□	□
Allergic/Immune: seasonal allergies, lupus	□	□	Hematologic/Lymph: anemia, excess bleeding	□	□
Cardiovascular: high cholesterol, arrhythmia	□	□	Musculoskeletal: arthritis, muscle pain	□	□
Ear/Nose/Throat: hearing loss, sinusitis	□	□	Neurological: seizures, numbness	□	□
Endocrine: diabetes, hormone dysfunction	□	□	Psychiatric: depression, anxiety	□	□
Gastrointestinal: heartburn, ulcer, diarrhea	□	□	Respiratory: asthma, cough, bronchitis	□	□

Social History

	Yes	No		Yes	No
Do you drink alcohol?	□	□	Any history of illegal drug use?	□	□
Do you use tobacco products?	□	□	Are you pregnant/nursing?	□	□

How did you hear about us?

□ Location □ Internet □ Mail □ Insurance □ Friend/Family □ Other:_____

The above questions were answered to the best of my knowledge. I hereby consent to a health examination, related diagnostic procedures and treatments provided by Ranch Road Vision Source. I understand that payment is due at the time of service, and agree to pay for any and all services/product rendered to me at Ranch Road Vision Source.

X_____ _____/____/_____ _____

Patient/Guardian Signature Date Relationship to patient, if guardian