

Reno Family Eye Care, P.C  
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# Welcome Back to Our Office

**Today's Date** \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Cell/Work Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Patient's Social Security Number: \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F  
 Employer (or School): \_\_\_\_\_  
 Occupation (or Grade): \_\_\_\_\_  
 Spouse (or Parent's Name): \_\_\_\_\_  
 Spouse (or Parent's Work): \_\_\_\_\_

**What is the major purpose of this visit?**

Any problems with your present contact lenses or glasses?

Did you receive a reminder postcard in the mail?  Yes  No

## Insurance Information

**Vision Insurance:** \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_  
 Subscriber Social Security Number: \_\_\_\_\_  
 Subscriber Birth Date: \_\_\_\_\_

**Medical Insurance:** \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_  
 Subscriber Social Security Number: \_\_\_\_\_  
 Subscriber Birth Date: \_\_\_\_\_

Do you participate in a flex spending account? Y N  
 How will you settle your account today?  
 Cash  Check  Credit Card

## Family Eye/Medical History

**Is there a family medical history of any of the following?**

	Relationship
Blindness	<input type="radio"/> _____
Cataracts	<input type="radio"/> _____
Corneal Problems	<input type="radio"/> _____
Glaucoma	<input type="radio"/> _____
Lazy Eye	<input type="radio"/> _____
Macular Degeneration	<input type="radio"/> _____
Retinal Problems	<input type="radio"/> _____
Diabetes	<input type="radio"/> _____
Heart Disease	<input type="radio"/> _____

**The information on this confidential case history form is critical in the evaluation of your vision and health.**

## Patient Medical History

Name of Family Physician \_\_\_\_\_  
 Office Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of Last Physical Check-up \_\_\_\_\_

### CURRENT MEDICATIONS (Rx or Over the Counter)

List all medications, including eye drops, vitamins & birth control:

Allergies to Medications?  Yes  No

Tobacco Use:  No  Yes Amount \_\_\_\_\_ Pack/Day

WOMEN ONLY: Are you currently pregnant?  Yes  No

### Have you ever been diagnosed or treated for the following?

Allergies  Diabetes  Thyroid  
 Arthritis  Heart Disease  Other \_\_\_\_\_  
 Asthma  High Blood Pressure \_\_\_\_\_  
 Cancer  Kidney \_\_\_\_\_  
 Cholesterol  Neurologic \_\_\_\_\_

## Patient Eye History

Date of Last Eye Exam \_\_\_\_\_

By whom? \_\_\_\_\_

Do you currently wear glasses? Yes No Contacts? Yes No

Are you satisfied with the vision and comfort?  Yes  No

What kind of contact lenses do you wear? \_\_\_\_\_

Replacement Schedule \_\_\_\_\_

Do you ever sleep in your lenses? \_\_\_\_\_ Solutions \_\_\_\_\_

Are you interested in trying contact lenses?  Yes  No

Have you had Vision Correction Surgery?  Yes  No

If so, where and when? \_\_\_\_\_

Do you... (Check if your answer is yes)

- ...work at a computer
- ...think you may benefit from thinner, lighter lenses?
- ...have interest in a "Test Drive" of the latest in contact lens?
- ...spend time outdoors? \_\_\_\_\_ hrs/week
- ...have prescription sunglasses or more than 1 pair of glasses?
- ...want information on Laser Vision Correction Surgery?
- ...have interest in a non-surgical approach to vision correction?
- ...have children?
- ...have family members in need of eye care?

If you wear traditional bifocals, does the line or head tilting bother you?  Yes  No

### Have you ever been diagnosed or treated for the following?

Cataracts  Iritis / Uveitis  
 Corneal Abrasion  Lazy Eye  
 Eye Infection  Macular Degeneration  
 Eye Injury  Retinal Detachment  
 Glaucoma  Other Eye Disorders \_\_\_\_\_

### Are you experiencing any of the following?

Blurry Vision  Headaches  
 Burning  Itching  
 Crossed Eye / Eye Turn  Night Vision Problems  
 Double Vision  Sunlight sensitivity  
 Dryness / Grittiness  Tearing  
 Flashes of light  Uncomfortable glasses  
 Floaters  Other \_\_\_\_\_