



Shannon Mihalacki, OD
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Welcome!

Today's Date _____

Patient Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Home Phone _____
 Cell Phone _____
 Date of Birth _____ Age _____
 Sex M F
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____

Email Address _____

What brought you in today?

Any problems with your current contact lenses or glasses? Yes (Will discuss with the doctor)
 No

How many pairs of current prescription glasses do you own? _____

Who may we thank for referring you to our office?

If you were not referred, how did you hear about us?
 Insurance list
 Saw Sign or Building
 Newspaper/ Newsletter
 Yellow Pages: Which Directory? _____
 Web Page: Which Site? _____
 Other _____

Insurance Information

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Do you participate in a flex spending account?
 Yes No

How will you settle your account today?
 Cash Check Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)

..work at a computer? If yes- how many hours/day? _____
 ..think you might benefit from thinner, lighter lenses?
 ..spend time outdoors? How much? ___Hrs/week
 ..have prescription sunwear?
 ..prefer not to wear your glasses at times?
 ..drive at night?
 ..want information on Laser Vision Correction surgery?
 ..have more than 1 pair of current Rx eyewear?
 ..feel your eyes are tired?
 ..have children?
 ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corneal Abrasions
<input type="checkbox"/> Crossed eye/Eye turn	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Flash of light	<input type="checkbox"/> Floaters/Spots
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Grittiness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Itchiness	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Occasional dryness
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Tearing	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Uncomfortable glasses	
<input type="checkbox"/> Other eye disorders _____	

Our Mission is to care for each person seen at Clear Vision Family Eyecare in such a respectful, memorable way that when the day is done you share your experience with another.

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

Patient Medical History	
Name of Family Physician _____	
Town _____	
Date of Last Physical Check-up _____	
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____	

Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	

Are you currently pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been diagnosed or treated for the following health problems?	
	Yes No
Chills/Fever	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>
Sudden weight loss/gain	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
High Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
Ear/Nose or Throat	<input type="checkbox"/> <input type="checkbox"/>
Respiratory	<input type="checkbox"/> <input type="checkbox"/>
Digestive	<input type="checkbox"/> <input type="checkbox"/>
Genitourinary	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/> <input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/> <input type="checkbox"/>
Neurological	<input type="checkbox"/> <input type="checkbox"/>
Psychological	<input type="checkbox"/> <input type="checkbox"/>
Endocrine	<input type="checkbox"/> <input type="checkbox"/>
Blood disorder	<input type="checkbox"/> <input type="checkbox"/>
Allergies	<input type="checkbox"/> <input type="checkbox"/>
Kidney	<input type="checkbox"/> <input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>
Other	<input type="checkbox"/> <input type="checkbox"/>
Please describe any "yes" below:	

Patient Eye History	
Last Eye Doctor: _____	
When was last eye exam? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship
Glaucoma	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Disease	<input type="checkbox"/> _____
Blindness	<input type="checkbox"/> _____
Eye Turn/Cross	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____
Other	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Clear Vision Family Eyecare.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you will be responsible to all charges and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Signature _____



Because There is so Much to See.