WELCOME BACK TO THE OFFICE

Today's Date ______________________

Patient Information

Last ______________________
First ________________ MI __________
Street ______________________
City ____________ State ____________
Zip Code ______________________
Home Phone ______________________
Work Phone ______________________
Patient's SSN ______________________
Employer (or School) ______________________
Occupation (or Grade) ______________________
Spouse (or Parent's Name) ______________________
Spouse (or Parent's Work) ______________________
Date of Birth ________________ Age ________
Sex M F
Email Address ______________________

What is the major purpose of this visit?
____
____

Any problems with your current contact lenses or glasses?
____
____
____

Dr. Joseph Johll and the Staff of Family Eyecare of Winterset P.C. are dedicated to ensuring high quality eye health care while providing the most accessible, experienced, comprehensive patient care possible. Our goal is to exceed our patients' expectations with state of the art vision care and efficient, caring and friendly service.
Our practice is committed to staying in the forefront of eye care technology with the latest instrumentation and continuing education for the Doctor and Staff.
Our mission is to provide the highest quality of life for you, your family and our community in the years to come.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

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, please complete computer questionnaire.
- ❑..think you might benefit from thinner, lighter lenses?
- ❑..have interest in a "test drive" of the latest contact lens designs
- ❑..spend time outdoors? How much? __Hrs/week
- ❑..have prescription sunwear?
- ❑..prefer not to wear your glasses at times?
- ❑..want information on Laser Vision Correction surgery?
- ❑..have interest in a non-surgical approach to vision correction?
- ❑..have more than 1 pair of current Rx eyewear?
- ❑..have children?
- ❑..have family members in need of eyecare?

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

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

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? ❑ Yes ❑ No
If so, what medications?____________________
____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam____________________
By Whom?____________________

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?____________________
Solutions used____________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

		Relationship (Mother's or Father's side)
Blindness	❑	____________________
Cataracts	❑	____________________
Corneal Problems	❑	____________________
Diabetes	❑	____________________
Glaucoma	❑	____________________
Heart Disease	❑	____________________
Lazy Eye	❑	____________________
Macular Degeneration	❑	____________________
Retinal Problems	❑	____________________

Computer User Questionnaire

Many people experience a variety of symptoms after working at their computer for some period of time. Surprisingly, many don't relate those symptoms directly to using the computer. Instead, they mistakenly attribute headaches and tired eyes to overall stress at work, rather than to visual fatigue that can be alleviated simply with the proper eyewear prescription.

If you experience any of these symptoms, please indicate the level of discomfort below:

Symptom	*Mild*	*Moderate*	*Severe*
Headaches during or after working at the computer	____	____	____
Overall bodily fatigue or tiredness	____	____	____
Burning eyes	____	____	____
Distance vision is blurry when looking up from the computer	____	____	____
Dry, tired or sore eyes	____	____	____
Squinting helps when looking at the computer	____	____	_____
Neck, shoulders, or back pain	____	_____	_____
Double vision	____	_____	_____
Letters on the screen run together	____	_____	_____
Driving/night vision is worse after computer use	____	_____	_____
"Halos" appear around objects on the screen	____	_____	_____
Need to interrupt work frequently to rest eyes	____	_____	_____

If you experience any of these symptoms, we offer a new type of eyewear lens that can eliminate the symptoms and dramatically improve your comfort level when working on a computer. These eyewear lenses result from new technology developed specifically for computer users. Our office has been trained and certified to pass this exciting technology on to you.

Please give this questionnaire to the Doctor for an explanation of how these eyewear lenses can help you.

Patient name: ____________________________________ Date: _______________