FIRSTSIGHT VISION SERVICES, INC.

Patient Registration and Health History

Date: _____

☐ Mr. ☐ Mrs. ☐ Ms.

☐ Female ☐ Male

First Name: _____ Last Name: _____ Age: _____ Birth Date: _____

Parent's Name (If patient is a minor): _____ If a student, Grade: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Type ☐ Cell ☐ Home Work Phone: _____

Emergency Contact Phone: _____ E-mail Address: _____

Occupation: _____ Have you had your eye exam at this office before? ☐ Yes ☐ No

What is the reason for seeking vision care at this time? _____

_____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent Insured's Date of Birth: _____

Insured's Name: _____ Insured's Employer: _____

Insured's ID: _____ Insurance Plan Name: _____ Auth. No.: _____

☐ Please check this box if there have been no changes to your medical and ocular history since your last visit at this office.

Do you consider your health: ☐ Good ☐ Fair ☐ Poor

Patient's Visual Symptoms
(Check each you have had)

- ☐ None, routine eye exam
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Burning eyes
- ☐ Discomfort at NEAR tasks
- ☐ (e.g., reading, sewing)
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye strain
- ☐ Headaches related to eyes
- ☐ Itching eyes
- ☐ Light sensitivity
- ☐ Red eyes
- ☐ See flashing lights
- ☐ See floaters or spots
- ☐ Temporary loss of vision
- ☐ Twitching eyelids
- ☐ Variable vision
- ☐ Watery eyes
- ☐ Other

Patient's Health History
(Check each you have had)

- ☐ None
- ☐ Allergies
- ☐ Asthma
- ☐ Blackouts
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Drug sensitivity
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Lazy eye (Amblyopia)
- ☐ Migraine headaches
- ☐ Macular Degeneration
- ☐ Poor color vision
- ☐ Skin conditions
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Turned eye
- ☐ Other

Family Health History
(Check each if someone in your family has had)

- ☐ None
- ☐ Allergies
- ☐ Asthma
- ☐ Blackouts
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Drug sensitivity
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Lazy eye (Amblyopia)
- ☐ Migraine headaches
- ☐ Macular Degeneration
- ☐ Poor color vision
- ☐ Skin conditions
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Turned eye
- ☐ Other

When was your last eye exam? _____ What is your previous eye doctor's name? _____

Have you had any serious eye disease, eye injury, or eye surgery? ☐ Yes ☐ No

If yes, please explain: _____

Do you wear contact lenses? ☐ Yes ☐ No

If yes, which type? ☐ Hard ☐ Soft ☐ Disposable

When was your last visit to your medical physician? _____ What is your medical physician's name? _____

For Women: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you smoke, consume alcohol, or use recreational drugs? ☐ Yes ☐ No

If yes, please explain: _____

Are you presently taking any medication or drugs? ☐ Yes ☐ No

If yes, what drugs are you taking? _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, which? _____

Signature: _____ Date: _____

Voluntary Language Survey

1.) What is your preferred spoken language?
☐English ☐Spanish ☐Chinese ☐Korean ☐Tagalog ☐Vietnamese ☐Other _____

2.) What is your preferred written language?
☐English ☐Spanish ☐Chinese ☐Korean ☐Tagalog ☐Vietnamese ☐Other _____

3.) What is your race?
☐White ☐American Indian / Alaskan Native ☐Asian ☐Black / African American ☐Native Hawaiian / Pacific Islander ☐Other _____

4.) What is your ethnicity? ☐Of Hispanic or Latino origin ☐Non Hispanic or Latino origin

☐ I decline to participate in this survey.

SUBJECTIVE

Name: DOB Age M F Interpreter Refused ☐ Date

Chief Complaint / History

HPI: Mild, Mod., Severe // Location: //Duration: //worse, better, same
*Please see intake for current medications, allergies, family and self medical conditions

Head / Face: Normal
Psych: Normal (anxiety, agitation, depression)
Neuro: Normal (orient: person, time, place)

Current Glasses
OD _____
OS _____
SVD SVN BF TF PAL

Current Contact Lenses
OD _____
OS _____
Care System WT___h

OBJECTIVE

VA's ☐cc ☐sc ☐PH ☐NVA

OD	20/	20/	20/	20/
OS	20/	20/	20/	20/
OU	20/	20/	20/	20/

Hirschberg

Color:
OD ____/____
OS ____/____
Stereo ____sec

PHOROMETRY

Distance
LPh_____VPh_____
BI / / BU /
BO / / BD /
Amps: ___/___/___

Near
LPh_____VPh_____
BI / / BU /
BO / / BD /
NRA/PRA/BCC ___/___/___

CT 6m cc/sc _____
40cm cc/sc _____
EOMs: ☐Full ☐Smooth OU

Pupils ☐PERRLA ☐-☐+ APD
Conf ☐FTFC OD, OS ☐ see notes
NPC ☐TTN _____

Tono: OD _____@_____ ☐ Auto VF: No Misses
NCT ☐ OS _____
GAT ☐ ☐igtt Fluress / Proparacaine

☐Ret OD _____
☐ARef OS _____ PD _____/_____

Keratometry OD_____ BP:____/____
OS_____ ☐ RAS @ ____
☐ LAS

Subjective: ADD:

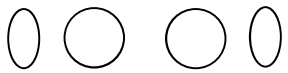
OD	20/	20/
OS	20/	20/

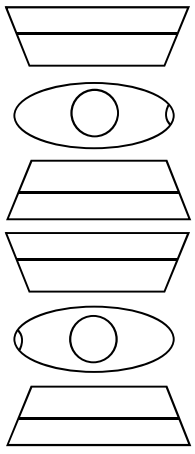
DPA's ☐igtt Tropicamide (1% or 0.5%) OU ☐Other _____
@ ____ ☐igtt Phenylephrine (2.5%) OU ☐igtt Proparacaine

SLExam OD OS ☐ALL Normal ☐=WNL

	OD	OS
LLL	☐	☐
Conj.	☐	☐
Cornea	☐	☐
A.C.	☐	☐
Iris	☐	☐
Lens	☐	☐
Vitreous	☐	☐

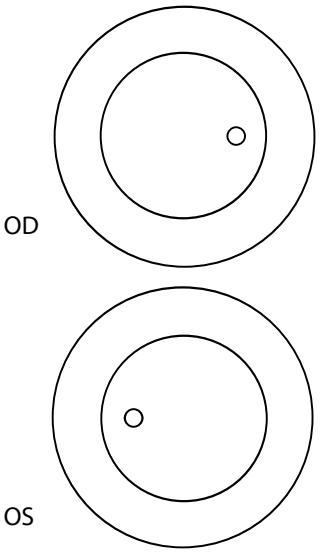
Angle ___/___ _____





Fundus: ALL Normal OD OS
Dilated: Yes/No DO/BIO/90D/78D

Media	☐	☐
Nerve Head:	☐	☐
C/D	___	___
Margin	☐	☐
Rim	☐	☐
Post. Pole:		
A/V	___	___
Macula	☐	☐
Vessels	☐	☐
	☐	☐
Periphery	☐	☐



DIAGNOSTIC CL FITTING

CL FITTING

Dx CL / Power / BC	OR	VA	Assess

ASSESSMENT

☐Good Fit, Comfort, VA OU
☐No Contraindications to CL wear
☐Patient Proficient w/ INR

PLAN

☐ Trial Pair Given, RTC 1 wk for F/U ☐ RT if pain/discharge, D/C CL ASAP
☐ Wear Time _____ hrs max
☐ CLRX Released ☐ Solu _____

NOTES

ASSESSMENT

Refractive Dx:

OD	☐Myopia	☐Hyperopia	☐Astigmatism	☐Presbyopia
OS	☐Myopia	☐Hyperopia	☐Astigmatism	☐Presbyopia

Ocular Health Dx: ☐NAP ☐Other _____

Binocularity: ☐SBV ☐ _____

PLAN

☐ No Rx Needed ☐ Rx Δ Opt. ☐ New Rx

Final SRX: ☐OD
☐OS
☐ADD

☐ _____

☐ Trial Framed Results Acceptable

PT ED

Return Visit: ☐1 Yr or PRN ☐ _____

☐Adaption to Rx ☐Glc Suspect ☐S/S of RD, RTC STAT if Sx
☐HTN ☐Risk of DFE ☐Decreased Va
☐DM ☐Other _____
☐No PCP Referral Needed ☐Refusal of DFE Noted
☐Referral to Ophthalmologist

X _____