Sacramento Visioncare Optometric Center Questionnaire

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name ______________________ First Name ______________________
If Child, Guardian's Name ______________________ Referred By ______________________
Address ______________________ City ______________ State ________ Zip ________
Work Phone ______________ Home Phone ______________ Cell Phone ______________
Email ______________________ SS# ______________________
Date of Birth ______________ Occupation ______________________
Emergency Contact Name ______________________ Phone Number ______________________
Primary Vision Coverage ______________ HMO PPO Secondary Coverage ______________ HMO PPO
Plan Member Name ______________________ Responsible Party if Insurance doesn't pay ______________________

Why are you here?

Check all that apply:

- ❑ **Chief Complaint** ______________________
- ❑ **New Patient Exam**
- ❑ **Follow Up Exam**
- ❑ **Yearly Exam**
- ❑ **Contacts**
- ❑ **Glasses**
- ❑ **Vision Improvement**
- ❑ **Other** ______________________

Please tell us what you want, need, or would like to know more about.

Refractive surgery?	**Yes**	**No**
Contacts?	**Yes**	**No**
To improve vision?	**Yes**	**No**
Sports vision?	**Yes**	**No**
Improved color vision?	**Yes**	**No**
Glasses in about an hour?	**Yes**	**No**
Vision Therapy (eye exercises)?	**Yes**	**No**
Nutrition advice related to vision?	**Yes**	**No**
Improve learning for self/others?	**Yes**	**No**
Computer glasses?	**Yes**	**No**
Improve vision w/o glasses or contacts?	**Yes**	**No**
Other: ______________________		

Medical Information

How is your general health? ______________________
Do you take medications for any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Auto Immune	Yes/No

Current Medications ______________________

Diabetes Yes/No Type ______________ Date of diagnosis ______________
Allergies to medication Yes/No Which? ______________ Reactions? ______________
Other health problems) ______________________
Have you had any operations? Yes/No Kind? ______________ When? ______________
Name of family doctor/primary care physician ______________ Phone ______________ Date of last visit ______________

Family History - Indicate if yourself or which relative

High blood pressure	Yes/No	Relation ________	Macular degeneration	Yes/No	Relation ________
Diabetes	Yes/No	Relation ________	Retinal detachment	Yes/No	Relation ________
Diabetic Retinopathy	Yes/No	Relation ________	Cataracts	Yes/No	Relation ________
Glaucoma	Yes/No	Relation ________	High Cholesterol	Yes/No	Relation ________
Heart Disease	Yes/No	Relation ________	Other		Self/Relation ________

SEE OVER

EYE HEALTH HISTORY

List your hobbies ____________________

____

____

____

Date of last eye exam ____________

Dilated? ❑ Yes ❑ No

Name of doctor ____________

Do you wear glasses? ❑ Yes ❑ No

❑ All the time ❑ Occasionally

❑ Reading ❑ Driving ❑ TV

Do you wear contacts? ❑ Yes ❑ No

Type ________ Hours/Day ______

Describe any problems you have with your contacts ____________________

____

Place a mark on "Yes" or "No' to indicate if you have had any of the following:

Bloodshot Eyes	❑ Yes ❑ No	Floaters or Spots	❑ Yes ❑ No
Blurred Vision - Distance	❑ Yes ❑ No	Headaches	❑ Yes ❑ No
Blurred Vision - Near	❑ Yes ❑ No	Itching Eyes	❑ Yes ❑ No
Burning Eyes	❑ Yes ❑ No	Light Sensitive	❑ Yes ❑ No
Color Vision, Poor	❑ Yes ❑ No	Loss of Vision	❑ Yes ❑ No
Crossed Eyes	❑ Yes ❑ No	Migraine Headaches	❑ Yes ❑ No
Discharge from Eyes	❑ Yes ❑ No	Night Vision, Poor	❑ Yes ❑ No
Dizzy Spells	❑ Yes ❑ No	Red Eyes	❑ Yes ❑ No
Double Vision	❑ Yes ❑ No	Seeing Halos	❑ Yes ❑ No
Dry Eyes	❑ Yes ❑ No	Seeing Flashes	❑ Yes ❑ No
Eye Infection	❑ Yes ❑ No	Temporary Loss of Vision	❑ Yes ❑ No
Eye Injury	❑ Yes ❑ No	Twitching Eyelid	❑ Yes ❑ No
Eye Strain	❑ Yes ❑ No	Vision Poor	❑ Yes ❑ No
Fainting Spells, Blackouts	❑ Yes ❑ No	Watering Eyes	❑ Yes ❑ No

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ YES I would prefer to discuss my Social History Information directly with my doctor. (check box)

Do you drive? ❑ NO ❑ YES If yes, do you have visual difficulty when driving? ❑ NO ❑ YES If yes, please describe:

____

Do you use tobacco products? ❑ NO ❑ YES If yes, type/amount/how long: ____________________

Do you drink alcohol? ❑ NO ❑ YES If yes, type/amount/how long: ____________________

Do you take supplements? ❑ NO ❑ YES If yes, which ones? ____________________

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment or authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to:

____________________ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____________________ ____________
Signature of Beneficiary, Guardian or Personal Representative — Date

____________________ ____________
Please print name of Beneficiary, Guardian or Personal Representative — Relationship to Beneficiary

Doctor Use Only

Reviewed by ____________________ ❑ No changes Date ____________

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Reviewed by ____________________ ❑ No changes Date ____________

Reviewed by ____________________ ❑ No changes Date ____________

For Office Use Only:

OCT:
❑ Yes ❑ No ❑ Maybe