



Vision Source! A Network of Premier Eye Care Practices
Dr. Amir Khoshnevis
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Welcome to Our Office

What is the main purpose of today's visit?
Any problems with your current glasses or contact lenses?
Are you interested in purchasing new glasses today?

Today's Date

Patient Information

Last Name
First Name
Street
City State Zip Code
Home Phone
Work Phone
Email Address
Patient's SSN
Date of Birth Age
Employer (or School)
Occupation (or Grade)
Spouse or Parent
Spouse or Parent Work Number

Patient Eye History

Date of last eye exam?
By Whom?
Do you currently wear glasses?
How old are the lenses in your current glasses?
Do you currently wear contact lenses?
What kind or brand?
Solutions Used
How often do you replace your contact lenses?
Do you sleep in your contact lenses?
Are you satisfied with the vision and comfort of your contact lenses?
Are you interested in changing your eye color?

Insurance Information

Vision Insurance
Primary Medical Insurance
Insured's Name
Insured's SSN
Insured's Birth Date
Relationship to Insured
Do you participate in a flex spending account?
How will you settle your account today?

Do you experience or have you ever experienced?
Tearing, Itchiness, Loss of vision, Burning, Sunlight sensitivity, Loss of side vision, Grittiness, Crossed eye / Eye turn, Distorted vision, Dryness, Floaters / spots, Double vision, Redness, Flashes of light, Trouble seeing at night
Have you been diagnosed or treated for any of the following?
Cataracts, Glaucoma, Macular Degeneration, Eye infection, Iritis/Uveitis, Retinal Detachment, Eye injury, Lazy eye, Other

VERY IMPORTANT! New Patients Only:
Whom may we thank for referring you to our office?

If not referred, how did you choose our office for your needs?
Another Doctor, Insurance, Saw Sign/Building, Web Page, Other, Yellow Pages, Yellow Book, Newspaper

Patient Medical History

Name of Family Physician
Date of Last Check-up
Town

Current Medications (Use back of sheet if necessary)
List medical allergies

Lifestyle Questions

Do you... (Check box if answer is yes)
Work at a computer?
Think you might benefit from thinner, lighter lenses?
Have more than one pair of current prescription glasses?
Spend time outdoors?
Have prescription sunglasses?
Prefer not to wear glasses at times?
Want information on Laser Vision Correction?
Have interest in a non-surgical approach to vision correction?
Have children?
Have family members in need of eyecare?
If you wear bifocals, does the head tilting or lines bother you?
Have you ever tried contact lenses?
Please list your hobbies:

Have you been diagnosed or treated for any of the following?
Heart Disease, High Blood Pressure, Lung Disease, Kidney problems, Liver problems, Thyroid problems, Diabetes, Stroke, Asthma, Cancer, Arthritis, Lupus, Head Trauma, Seizures, Migraines, STD, Are you pregnant?, Breastfeeding?

Family Medical / Eye History

Is there a family history of any of the following?
(*Parents, siblings, children, grandparents*)
Diabetes, High Blood Pressure, Heart Disease, Cancer, Glaucoma, Lazy Eye, Macular Degeneration, Retinal Detachment