

CHIEF COMPLAINT

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

- | | | | | |
|----------------------------|--------------------------|-----|--------------------------|----|
| Blurry vision-Near | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Blurred vision-Distance | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Burning eyes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Cataracts | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Color vision poor | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Crossed or Turned eyes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Discharge from eyes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Dizzy spells | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Double vision | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Dryness | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Eye infection | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Eye injury | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Eye strain | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Eye pain | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Fainting spells, Blackouts | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Floaters or Spots | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Flashes of light | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Glaucoma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Headaches | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Itching eyes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Lazy eye | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Light sensitivity | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Loss of vision | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Macular degeneration | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Night vision, poor | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Redness | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Twitching eye | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Watering eyes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Other: | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

PATIENT HISTORY / REVIEW OF SYSTEMS

Place a mark on "Yes" or "No" to indicate if You have had any of the following:
Also place a mark to indicate if a blood relative has had any of the following:

- | | Yourself | | Family Members | |
|----------------------|--------------------------|-----|--------------------------|----|
| Amblyopia (lazy eye) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Blindness | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Keratoconus | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Lazy eye | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Glaucoma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Macular degeneration | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Strabismus eye turn) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Eye Surgery: | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| <hr/> | | | | |
| AIDS/HIV | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Allergies/Hay Fever | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Arthritis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Asthma | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Bleeding | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Cancer | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Diabetes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Drug Sensitivity | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Emphysema | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Epilepsy | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Heart Condition | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Hepatitis(type) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| High Blood Pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Kidney Disease | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Lupus | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Stroke | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Thyroid Conditions | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Tobacco Use | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Alcohol Use | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Other: | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

ALLERGIES:

List any allergies and allergies to medications:

MEDICATIONS:

List any medications you are currently taking, including eye drops:

I request that payment of authorized Medicare benefits and if applicable, Medigap benefits, be made either to me or on my behalf to Vision Onsite for any services furnished to me by that provider.

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 for related services.

Signature of Patient, Guardian or Personal Representative:

Date