Welcome to the Advance Vision Center!

To help us give you the best care possible, please answer all of the questions below.
If you're a returning patient, you only need to fill out the items that have changed since your last visit.

Today's Date:	Whom may we thank for referring you?	
Last Name:	First:	MI:
Address:		
City:	State:	Zip Code:
Work Phone:	Home Phone:	E-mail:
Date of Birth:	Social Security #:	Major Medical Insurance:
Vision Insurance:	Insurance Supplements:	
Parent/Spouse Name:		Phone #:
Date of last eye exam:		Were you dilated? □ Yes □ No □ Unsure

Medical Information		
What is your general health?		
Do you have any problems with any of these systems? (Please check all that apply)		
□ Gastrointestinal	□ Ears/Nose/Throat	□ Respiratory
□ High Blood Pressure	□ Nervous	□ Urinary
□ Skin	□ Eyes	□ Mental
□ Pregnancy	□ Other, please describe:	
Do you have diabetes? □ Yes □ No	If yes, what type? □ Type 1 □ Type 2	Is your glucose under control? □ Yes □ No
Any other health problems?		
What medications, if any, are you taking?		
Have you had any operations? □ Yes □ No	What was done?	
Family Doctor:	City, State:	Phone number:
Date of last visit:	Date of last tetanus shot:	

Family History (Please check all that apply and tell us who in your family had the condition)	
□ High Blood Pressure	□ Macular Degeneration
□ Diabetes	□ Retinal Detachment
□ Glaucoma	□ Cataracts

Personal Eye History (Please check all that apply)		
□ I work at a computer.	□ I sometimes experience dry eyes.	□ I am interested in thinner, lighter lenses.
□ I spend time outdoors (___ hours/week)	□ I have prescription sunglasses.	□ I prefer not to wear my glasses at times.
□ I would like information about Laser Vision Correction surgery.	□ I would like information about non-surgical vision correction procedures.	□ I have more than one pair of prescription eyeglasses.
□ I have children.	□ My family members need eyecare.	□ I have tried contact lenses in the past.
If you wear bifocals, do the lines or head tilting bother you? □ Yes □ No If so, when?		
If you wear contacts, are you happy with the vision and comfort? □ Yes □ No If not, why?		
Would you be interested in colored contact lenses to change the color of your eyes? □ Yes □ No		

Anything Else You'd Like to Share With Us