

**Dyer Vision Center, Inc.**  
**Patient Information Form**

Dr. \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_ Gender: M  F

Marital Status: Single  Married  Divorced  Widowed  Spouse's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT:** Self  Spouse  Parent  Other \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Gender: M  F  Insured's Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Vision Insurance Co: \_\_\_\_\_ Secondary Insurance Co: \_\_\_\_\_

Do you participate in a flexible spending account? Y  N  Insured's Social Security Number \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ How do you prefer to be contacted? Home  Work  Cell  Email

**PATIENT EYE, MEDICAL, AND LIFESTYLE HEALTH HISTORY**

Date of last eye exam: \_\_\_\_\_ Doctor: \_\_\_\_\_ Place: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of last office visit: \_\_\_\_\_

Have you had surgery within the past 12 months? Y  N  If yes, please describe: \_\_\_\_\_

Do you have?	Y	N	?	Diagnosed with?	Y	N	?	Diagnosed with?	Y	N	?
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Asthma / emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are they				3. Retina problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard	<input type="checkbox"/>			4. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>			5. Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other			
Toric (astigmatism)	<input type="checkbox"/>			6. Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Do You?</b>			
Spherical	<input type="checkbox"/>			7. Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you ever had?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Iritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use alcohol daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work in eye hazard area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work around toxic fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work around toxic materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other				12. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other			

Systems reviewed today:  \_\_\_\_\_ Reviewed from: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ System changes noted:  \_\_\_\_\_

Do you have problems with these systems?	Y	N	Do you have problems with these systems?	Y	N
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose and throat	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Mental	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (glands)	<input type="checkbox"/>	<input type="checkbox"/>
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Blood/lymph	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain: \_\_\_\_\_

List medications you are taking: \_\_\_\_\_

Are you allergic to any medications? Y  N  If yes, please list. \_\_\_\_\_

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Patient Name: \_\_\_\_\_

**FAMILY HISTORY**

Has a family member had?	Y	N	Relationship
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Other eye condition	<input type="checkbox"/>	<input type="checkbox"/>	

**PATIENT DIAGNOSTIC AND LIFESTYLE INFORMATION**

Do you have difficulty with these activities even with glasses?	Y	N	Right	Left
Reading small print, such as labels on RX bottles, telephone books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading a newspaper or book	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading a large print newspaper or large numbers on a telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing steps, stairs, or curbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading traffic signs, street signs, or store signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing fine handwork like sewing, knitting, or carpentry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing checks or filling out forms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking part in sports like bowling, tennis, or golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving during the day because of your vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving at night because of your vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you experience?</b>	<b>Y</b>	<b>N</b>		
Discomfort with your eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Problems with glare or reflection	<input type="checkbox"/>	<input type="checkbox"/>		
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>		
Headaches (more than 1 per week)	<input type="checkbox"/>	<input type="checkbox"/>		
Floaters or flashes of light	<input type="checkbox"/>	<input type="checkbox"/>		
Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>		
Seeing rings or halos around lights	<input type="checkbox"/>	<input type="checkbox"/>		
Hazy or blurry eyes	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Diagnostic Issues</b>	<b>Y</b>	<b>N</b>		
Do you have more than one pair of prescription glasses	<input type="checkbox"/>	<input type="checkbox"/>		
Do you work on a computer for long periods of time	<input type="checkbox"/>	<input type="checkbox"/>		
If you wear glasses, would you benefit from thinner, lighter glasses	<input type="checkbox"/>	<input type="checkbox"/>		
If you wear bifocals, are you bothered by head tilting or lines	<input type="checkbox"/>	<input type="checkbox"/>		
If you wear contacts, are you satisfied with your vision & comfort	<input type="checkbox"/>	<input type="checkbox"/>		

How did you hear about our office? Friend/family  Location  Yellow Pages  Lion's Club  Referral

Other \_\_\_\_\_

**CONSENT FOR TREATMENT**

I consent to an eye exam at Dyer Vision Center, Inc. including any procedures legally defined as the Practice of Optometry in Missouri. I understand and agree that I am financially responsible for my account if initially rejected by my insurer. I hereby authorize release of any information necessary to file an insurance claim. I also authorize the release of information to another doctor or other qualified person if necessary for my care.

Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_