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:
Gender: □ Male □ Female	E-mail:	
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Mobile Phone:
May we contact you via E-mail? □ Yes □ No		May we text you? □ Yes □ No
Date of Birth:	Social Security #:	Major Medical Insurance:
Vision Insurance:	Insurance Supplements:	
Parent/Spouse Name:		Phone:
How did you learn about our office?		

Medical Information

Date of last eye exam:		Were you dilated? □ Yes □ No □ Unsure
What is your general health?		
Do you have any conditions related to these systems? (Please check all that apply and describe)		
□ Gastrointestinal:	□ Ears/Nose/Throat:	□ Respiratory:
□ High Blood Pressure:	□ Nervous:	□ Urinary:
□ Skin:	□ Eyes:	□ Mental:
□ Pregnancy:	□ Other:	
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?		
To what medications are you allergic?		
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 (___ hours/week)	□ My eyes frequently itch, burn, or water.	□ 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 also need eye care.	□ I have tried contact lenses in the past.
If you wear bifocals or progressive lenses, 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		

Thank you! Please remember to rate your experience with us on Yelp and Google Latitude.
You can also follow us on Twitter @AdvanceVision, and find us on Facebook.