Patient Medical Intake Form

Name:____ DOB:____/____/____ Age:______ Marital Status S M D W

Address:____City:_______________State:____ ZIP______________

Home/Mobile #: ________________________________ Email:____

Employer:____ Occupation:__________________________

Emergency contact: ____________________ Relationship:___________________ Phone #: ____________________________

If minor: Guardian name: ____ Phone:____________________________________

VISION INSURANCE

Do you have vision insurance? ☐Y ☐N Vision Insurance Company: __________________________

MEDICAL INSURANCE

Do you have medical insurance? ☐Y ☐N _______________________ (Circle one) HMO/ PPO

Do you have Medicare? ☐Y ☐N

EYE HISTORY

Last eye exam: _______________ Do you currently wear glasses? ☐Y ☐N Age of present glasses:___________

Have you ever worn hard or soft contact lenses before? ☐Y ☐N Brand: _____________________________________

Are you interested in contact lenses? ☐Y ☐N Are you interested in lasik? ☐Y ☐N

Have you had any eye surgery/injuries? ☐Y ☐N If yes, list ____

Any ocular diseases? ☐Y ☐N If yes, list ____

Do you currently experience any of the following problems (circle one or more if there are multiples):

- ☐ eyestrain/fatigue
- ☐ dry eye
- ☐ floaters/ spots
- ☐ computer vision problems
- ☐ itchy/ red/ burning eyes
- ☐ flashes of light
- ☐ lazy eye/ crossed eyes/ double vision
- ☐ distance/ near vision blurry
- ☐ frequent headache related to eye

MEDICAL HISTORY

- ☐ Current Smoker
- ☐ Former Smoker
- ☐ Are you pregnant? / Breast feeding?
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Autoimmune
- ☐ Thyroid Disease
- ☐ Lung Problem
- ☐ Allergy
- ☐ Neurological
- ☐ Psychological
- ☐ Other:____________

Current Medication (Please List): ____

____

Drug/Medical Allergies (Please List): ____

Family Medical History of Eye Disease or Systemic (Please List): ____

____

Please list all past surgeries: ____

Notices & Informed Consent

Please initial (______) **Notice of Privacy Practices:**

I understand and have read the Notice of Privacy Practices form provided to me by Dr. Rebecca Bui Van OD and her staff.

Patient signature:____ Date:____________________