Welcome to Hills Vision Studio

Dr. Vinal Patel, O.D.

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

For Insurance Purpose:

Patient's Name:_____

DOB:____/____/____ **Last 4 SS#**_____ **Sex:**_____

Address:_____

City:_____ **Zip:**_____

Cell #:_____

Home #:_____

Vision Insurance:_____

Medical Insurance:_____

Email _____

Note: It is now required we obtain an email address so we can upload your visit to the patient portal

Responsible Member:_____

DOB:____/____/____ **Last 4 SS#:**_____ **Sex:**_____

Primary Language ☐ English ☐ Spanish ☐ Other

Special Needs: ☐ Hearing Impaired ☐ Translator ☐ Wheelchair

Race ☐ White ☐ African American ☐ Asian

☐ Other _____ ☐ Decline to Answer

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

☐ Unknown ☐ Decline to Answer

PCP Name:_____

Last PCP Visit _____/_____/_____ PCP #_____

Last Eye Exam _____/_____/_____

Prev. Eye Dr. _____

Miscellaneous

List any previous surgeries with dates

_____

_____

_____

Are You Pregnant? ☐ Yes ☐ No

Are You Nursing? ☐ Yes ☐ No

Hobbies/Recreational Sports you enjoy _____

_____

_____

How many hours per day do you use a computer? _____

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses? Brand:_____ ☐ Yes ☐ No

Are you interested in contact lenses? ☐ Yes ☐ No

Are you interested in refractive surgery? ☐ Yes ☐ No

Do you perform fine or close-up work? ☐ Yes ☐ No

Are you outdoors all or part of the time? ☐ Yes ☐ No

Do you have trouble reading signs when driving at night? ☐ Yes ☐ No

Are you bothered by glare from: Overhead lighting? ☐ Yes ☐ No

A computer screen? ☐ Yes ☐ No

Oncoming headlights at night? ☐ Yes ☐ No

Are you sensitive in bright sunlight? ☐ Yes ☐ No

Review of Systems

◯ Check here if none of the below is applicable

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐
Ears/Nose/Mouth/Throat		
Allergies	☐	☐
Sinus Congestion	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Mouth/Throat	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐

	Yes	No
Gastrointestinal		
Constipation	☐	☐
Crohn's Disease	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Ulcer / Reflux	☐	☐
Genito-Urinary		
Bladder / Genital / Kidney	☐	☐
Herpes Simplex	☐	☐
Prostate	☐	☐
Musculoskeletal		
Joint / Muscle Pain	☐	☐
Osteo Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Integumentary (skin)		
Skin Cancer	☐	☐
Skin Disease	☐	☐
Herpes Zoster/Shingles	☐	☐

	Yes	No
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Seizures	☐	☐
Psychiatric		
Anxiety / Depression	☐	☐
Endocrine		
Diabetes Type I	☐	☐
Diabetes Type II	☐	☐
Thyroid/Other Glands	☐	☐
Lymphatic – Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic / Immunologic		
Eczema	☐	☐
Hives	☐	☐
Lupus	☐	☐
Organ transplant	☐	☐

Please Complete Both Sides of the Form OVER →

Ocular History

(mark yes or no to each question) ◯ Check here if none of the below is applicable

Age-related macular degeneration	❑ Yes	❑ No	Injury to the eye region	❑ Yes	❑ No
Amblyopia (Lazy eye)	❑ Yes	❑ No	Keratoconus	❑ Yes	❑ No
Vision Impaired - one eye	❑ Yes	❑ No	Retinopathy	❑ Yes	❑ No
Vision Impaired - both eyes	❑ Yes	❑ No	Strabismus (Crossed eyes)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Tear film insufficiency (dry eyes)	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Other _____		
History of refractive surgery	❑ Yes	❑ No	_____		

Patient's Past Medical History

(mark yes or no to each question) ◯ Check here if none of the below is applicable

Acquired Immune Deficiency Syndrome (AIDS)	❑ Yes	❑ No	Human immunodeficiency virus infection (HIV)	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Hypercholesterolemia (high cholesterol)	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hypertensive disorder (Hypertension)	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Seasonal allergy	❑ Yes	❑ No
Chronic obstructive lung disease (COPD)	❑ Yes	❑ No	Thyroid dysfunction	❑ Yes	❑ No
Diabetes mellitus	❑ Yes	❑ No	Mental disorder	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Rheumatoid arthritis	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No			

Family Health History ◯ Check here if none of the below is applicable

(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

Amblyopia (Lazy eye)	❑ Yes	❑ No _____	Strabismus (cross eyes)	❑ Yes	❑ No _____
Blindness and/or vision impairment	❑ Yes	❑ No _____	Arthritis	❑ Yes	❑ No _____
Cataract	❑ Yes	❑ No _____	Cancer	❑ Yes	❑ No _____
Macular Degeneration	❑ Yes	❑ No _____	Diabetes mellitus	❑ Yes	❑ No _____
Glaucoma	❑ Yes	❑ No _____	Hypertension (high blood pressure)	❑ Yes	❑ No _____
Retinal disorder	❑ Yes	❑ No _____	Cardiovascular disease	❑ Yes	❑ No _____
			Stroke	❑ Yes	❑ No _____

Social History (check one for each question)

Do you use recreational Drugs? ☐ Yes ☐ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

☐ No Medications

_____

_____

_____

_____

Pharmacy Name:_____

Telephone #:_____

Medication Allergies

List any allergies you may have and reaction.

_____

_____

_____

_____

☐ No Medication Allergies

Signature:_____ **Date:**_____

◯ I agree that my electronic signature is the legal equivalent of my manual/handwritten signature on this document. By selecting "I agree" using any device, means, or action, I consent to the legally binding terms and conditions of this document.