

WELCOME TO OUR OFFICE



Today's Date _____

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Date of Birth _____ Age _____
Sex M F
Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

Dr. Joseph Johl and the Staff of Family Eyecare of Winterset, P.C. are dedicated to ensuring high quality eye health care while providing the most accessible experienced, comprehensive patient care possible. Our goal is to exceed our patients' expectations with state of the art vision care and efficient, caring and friendly service. Our practice is committed to staying in the forefront of eye care technology with the latest instrumentation and continuing education for the Doctor and Staff. Our mission is to provide the highest quality of life for you, your family and our community in the years to come.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a flex spending account?

- Yes No

How will you settle your account today?

- Cash Check Credit Card

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |

Patient Medical History	
Name of Family Physician _____ Town _____ Date of Last Physical Check-up _____	
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ _____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been diagnosed or treated for the following health problems?	
	Yes No
Allergies	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/> <input type="checkbox"/>
Bronchitis	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>
Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Digestive	<input type="checkbox"/> <input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/> <input type="checkbox"/>
Endocrine	<input type="checkbox"/> <input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>
Fevers	<input type="checkbox"/> <input type="checkbox"/>
Genitourinary	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/> <input type="checkbox"/>
Kidney	<input type="checkbox"/> <input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/> <input type="checkbox"/>
Neurological	<input type="checkbox"/> <input type="checkbox"/>
Psychological	<input type="checkbox"/> <input type="checkbox"/>
Respiratory	<input type="checkbox"/> <input type="checkbox"/>
Sinus	<input type="checkbox"/> <input type="checkbox"/>
Throat Infections	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/> <input type="checkbox"/>

Patient Eye History
Date of Last Eye Exam _____ By Whom? _____
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used _____
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No

Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Family Eyecare of Winterset PC.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.
CC#: _____
Expiration Date: _____

Signature _____





Computer User Questionnaire

Many people experience a variety of symptoms after working at their computer for some period of time. Surprisingly, many don't relate those symptoms directly to using the computer. Instead, they mistakenly attribute headaches and tired eyes to overall stress at work, rather than to visual fatigue that can be alleviated simply with the proper eyewear prescription.

If you experience any of these symptoms, please indicate the level of discomfort below:

<i>Symptom</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Headaches during or after working at the computer	_____	_____	_____
Overall bodily fatigue or tiredness	_____	_____	_____
Burning eyes	_____	_____	_____
Distance vision is blurry when looking up from the computer	_____	_____	_____
Dry, tired or sore eyes	_____	_____	_____
Squinting helps when looking at the computer	_____	_____	_____
Neck, shoulders, or back pain	_____	_____	_____
Double vision	_____	_____	_____
Letters on the screen run together	_____	_____	_____
Driving/night vision is worse after computer use	_____	_____	_____
"Halos" appear around objects on the screen	_____	_____	_____
Need to interrupt work frequently to rest eyes	_____	_____	_____

If you experience any of these symptoms, we offer a new type of eyewear lens that can eliminate the symptoms and dramatically improve your comfort level when working on a computer. These eyewear lenses result from new technology developed specifically for computer users. Our office has been trained and certified to pass this exciting technology on to you.

Please give this questionnaire to the Doctor for an explanation of how these eyewear lenses can help you.

Patient name: _____ Date: _____