

Guardian: _____ Date: _____
 Name: _____
 Address: _____
 City, St: _____ Zip: _____
 Phone(H): _____ W: _____ C: _____
 Date of Birth: _____ Sex: _____
 E-Mail: _____



Sugar House Vision
 2178 S 900 E #4
 SLC UT 84106

801-484-2020
 Sugarhousevision@gmail.com

Occupation: _____

Notify me by: Text Phone Email Mail

Who may we thank for referring you to our office?

Friend Insurance Phone Book Other...

Emergency Contact Name and Phone:

Approx. Date of Last Eye Exam: _____

Race American Indian or Alaska Native
 Asian
 Black or African-American
 Native Hawaiian or Other Pacific Islander
 Other Race
 Unknown/undetermined
 White

Ethnicity Hispanic or Latino Unknown
 Not Hispanic or Latino

Language English French Russian Other...
 Spanish Japanese Tagalog

Smoking 1 Current everyday smoker
 2 Current some day smoker
 3 Former smoker
 4 Never smoker
 5 Smoker, current status unknown
 9 Unknown if ever smoked

What is the major purpose of this visit:

- | | |
|---|---|
| <input type="checkbox"/> Blur at Far | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Blur at Near | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Blur at Far & Near | <input type="checkbox"/> Sandy/Gritty |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Spots or shadows |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Diabetes eye check |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Medical eye check |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Eye strain | |
| <input type="checkbox"/> Flashes/Floaters | |

Which Eye? Right eye Left eye Both eyes

How long has it bothered you?

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Started today | <input type="checkbox"/> 1-2 weeks | <input type="checkbox"/> 3-6 months |
| <input type="checkbox"/> 1-2 days | <input type="checkbox"/> 2-4 weeks | <input type="checkbox"/> Over 6 months |
| <input type="checkbox"/> 3-7 days | <input type="checkbox"/> 1-3 months | |

Severity? Mild Moderate Severe

Getting Worse?

- Getting better Getting worse About the same

Current Prescription:

Glasses: Right

Left

Contacts: Right

Left

Medical Doctor(s): _____

**Please note that insurance does NOT cover
 the Contact Lens Fitting Evaluation
 Vision or Primary Insurance**

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ Ins. Sex: M F

Co-pay: _____ Materials: Y N

Medical or Secondary Insurance

Ins. Name: _____

Ins Number: _____

Relationship: _____

Insured: _____

Insured DOB: _____ Ins. Sex: M F

Co-pay: _____ Materials: Y N

Participate in a flex spending account? Y N

Past Medical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> High B.P. | |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Keratoconus | |
| <input type="checkbox"/> Diabetes I | <input type="checkbox"/> Kidney | |
| <input type="checkbox"/> Diabetes II | <input type="checkbox"/> Lasik | |
| <input type="checkbox"/> Droopy Lid | <input type="checkbox"/> Lazy Eye | |
| <input type="checkbox"/> Ear Problem | <input type="checkbox"/> Macular Degen. | |
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Migraine | |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> MS | |

Social History

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Computer | <input type="checkbox"/> Fishing | <input type="checkbox"/> No alcohol or drug abuse |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Tennis | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Student | <input type="checkbox"/> Swim | |
| <input type="checkbox"/> Music | <input type="checkbox"/> Bike | |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Drug Abuse | |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Alcohol Abuse | |

Current Medicines

Amount

Eye wear History

- | | | | |
|------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> No-line | <input type="checkbox"/> Gas Perm | <input type="checkbox"/> Disposable |
| <input type="checkbox"/> Bifocals | <input type="checkbox"/> Soft Contacts | <input type="checkbox"/> Hard | <input type="checkbox"/> Overnight wear |
| <input type="checkbox"/> Trifocals | <input type="checkbox"/> Toric Soft | <input type="checkbox"/> Monovision | |

Mark box if yes.

- Have you tried contact lenses?
- Not satisfied with the vision comfort of your contact lenses?
- Would prefer colored contacts?
- Do the lines and head tilting bother you with bifocals?

Allergies

- | | | |
|-------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other... |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Eye drops | |

Family History

- | | |
|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Retina Detach |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> High B.P. |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> None |
| <input type="checkbox"/> Retina Disease | <input type="checkbox"/> Other... |

Lifestyle Questions

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

- | | |
|--|---|
| <input type="checkbox"/> Work at a computer often? | <input type="checkbox"/> Prefer not to wear your glasses at times? |
| <input type="checkbox"/> Think you might benefit from thinner lenses? | <input type="checkbox"/> Want info. on Laser Vision Correction surgery? |
| <input type="checkbox"/> Would like to "test drive" the latest contact lenses? | <input type="checkbox"/> Have more than 1 pair of current Rx eyewear? |
| <input type="checkbox"/> Spend time outdoors? | |

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance doesn't pay.** We charge \$2.00 every 2 weeks on balances over 60 days. **Contact lens fit and follow up care is billed separately from your eye exam.** Your information is protected by our privacy policy

I have received a copy of Sugar House Vision Clinic "Notice of Privacy Practices".

Remind me of my appointment by: Text

Signature _____ Date _____

Relationship to Patient: _____