

PATIENT HISTORY/LIFESTYLE

Are you a former patient? Yes No Year of last examination _____

	Yes	No	Sometimes
Can you see clearly in the distance? With glasses if worn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you see clearly when you read? With glasses if worn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does television annoy your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your eyes itch, burn or water excessively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your eyes appear excessively red or bloodshot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does indoor light bother your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does sunlight bother your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good physical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you now taking any medication or vitamin/mineral supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any eye diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family ever had any eye diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any injuries to your head or eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer with pain in your eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer with headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any visual problems not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is preventative eye care important to you?	<input type="checkbox"/>	<input type="checkbox"/>	

I participate in the following activities:

racquetball, tennis, squash	<input type="checkbox"/>	softball, baseball	<input type="checkbox"/>	snow skiing	<input type="checkbox"/>
swimming, scuba	<input type="checkbox"/>	basketball	<input type="checkbox"/>	play musical instrument	<input type="checkbox"/>
boating	<input type="checkbox"/>	football	<input type="checkbox"/>	jogging or cycling	<input type="checkbox"/>
golf	<input type="checkbox"/>	hockey	<input type="checkbox"/>	hunting/shooting	<input type="checkbox"/>

Check any of the items about which you have questions:

Contact Lenses <input type="checkbox"/>	Bifocals <input type="checkbox"/>	Invisible (no line) Bifocals <input type="checkbox"/>	Transitions Lenses <input type="checkbox"/>
Frames <input type="checkbox"/>	Trifocals <input type="checkbox"/>	Tinted Lenses <input type="checkbox"/>	Prescription Sunglasses <input type="checkbox"/>

How many years have you had your present lenses? _____

When do you wear your glasses? All the time For distance only For near only Never

Did you have any difficult adjusting to your present lenses? Yes No

ACKNOWLEDGEMENT OF RECEIPT

HIPAA NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPAA policy set forth by Montgomery Vision Care.
I acknowledge that I was offered a copy of Dr. Fiorenza's Notice of Privacy Practices.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient