Hertneky Vision Source
212 Cameron Street Brush, Colorado 80723

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Welcome to our office. The information you complete here will allow us to give you the best care!

Patient Name: ______________________ Phone Home: ______________ Cell: ______________

Mailing Address: ______________________ City: ______________ Zip: ________ Sex: M or F

Birth Date: __________ Social Security#: __________ Email Address: ______________________

Race: White [ ] Asian [ ] African American/Black [ ] Native Hawaiian/Pacific Islander [ ] American Indian/Alaska Native [ ] Unknown [ ]

Ethnicity: Hispanic/Latino [ ] Not Hispanic/Latino [ ] Preferred Language: __________ Previous Eye Doctor: __________

Last Eye Exam: __________ Name of Medical Doctor: ______________ Last Medical Exam: __________

Employed: Y / N Employer: ______________ Work Phone: ______________ Ext: __________

Married: Y / N Spouse's name: ______________ Date of Birth: __________ Social Security # : __________

For Ages 0-18: Mother's Name ______________ Birth Date: __________ Social Security # __________

Father's Name ______________ Birth Date: __________ Social Security# __________

Family Members: Name: ______________ Age: ______ Name: ______________ Age: ______

Insurance Information: Please present **ALL** Vision and Medical Insurance cards at time of visit. It is beneficial for you to have both types of insurance information on file since medically related eye exams and procedures may be covered by your primary medical policy.

Who is responsible for this account? __________ Please circle a payment option: Cash Check Credit Card HSA/Flex Plan Care Credit

How did you hear about us: Family Friends Hospital/Doctor Yellow Pages Insurance List
Sign/Building Mailing/Newsletter Newspaper Radio Website Other __________

Reason for Visit: ____

Purchasing Plans: [ ] New eyeglasses [ ] New Prescription Sunglasses [ ] New Non-prescription Sunglasses [ ] New Computer Eyeglasses
[ ] New Reading glasses [ ] New Sport Eyeglasses [ ] New supply of contact lenses [ ] New contact lens fit

Are there any hobbies, sports, activities, work environments, or leisure where your eyes gets strained, vision gets blurry, or you do not feel your glasses or contacts work good enough? ______________________

Medical History:

Is there anything about your eye health that worries you? Y / N If so, what is it? ______________________

Please list **all medications** including oral contraceptives, aspirin, over the counter medications and home remedies:

Drug Name	Dose	Taken when/how often	Drug Name	Dose	Taken when/how often

Any **Allergies** to medications: No [ ] Yes [ ] If yes, explain: ______________________

List all major injuries, surgeries and/or hospitalizations you have had: ______________________

Do you wear glasses? No [ ] Yes [ ]
If yes, how old is your present pair of lenses? __________

Do you wear contact lenses? Y [ ] N [ ]
Brand Name: __________ Power: __________ Base Curve: ______

Social History: DO YOU...

Drive? Y [ ] N [ ] If yes, do you have visual difficulty when driving? Y [ ] N [ ] If yes, please describe: __________ Commute East or West?

Use tobacco products? Y [ ] N [ ] **If yes, type:** cigarette/ cigar/ pipe/ smokeless **how often:** __________

Drink alcohol? Y [ ] N [ ] **If yes,** # ______ drinks per day/ week/ month

PLEASE CONTINUE TO THE NEXT PAGE (OR) OTHER SIDE

Family History:

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions:
Please mark Self and/or Family

Disease/Condition	Self	Family	Relation to you
Amblyobia	[ ]	[ ]	______________
Cataract	[ ]	[ ]	______________
Crossed Eyes	[ ]	[ ]	______________
Glaucoma/Suspect	[ ]	[ ]	______________
Macular Degeneration	[ ]	[ ]	______________
Retinal Detachment	[ ]	[ ]	______________
Nystagmus	[ ]	[ ]	______________

Disease/Condition	Self	Family	Relation to you
Cancer	[ ]	[ ]	______________
Diabetes	[ ]	[ ]	______________
High Blood Pressure	[ ]	[ ]	______________
Heart Disease	[ ]	[ ]	______________
Thyroid Disease	[ ]	[ ]	______________
Other______________	[ ]	[ ]	______________

Circle any of the following that you may have/had:

Lazy eye / Drooping eyelid / Prominent eyes / Retinal disease / Eye infections / Eye injury

Review of Systems

Do you currently or ever had any problems in the following areas: (Please circle all that apply)

OCULAR:
- Loss of Vision
- Blurred Vision
- Distorted Vision/Halos
- Double Vision
- Dryness
- Mucous Discharge
- Redness
- Sandy or Gritty Feeling
- Itching
- Burning
- Foreign Body Sensation
- Excess Tearing/Watering
- Glare/Light Sensitivity
- Eye Pain or Soreness
- Chronic Infection of Eye
- Chronic Infection of Lid
- Sties or Chalazion
- Flashes/Floaters in Vision
- Tired Eye
- Other

CONSTITUTION:
- Developmental disability
- Cancer
- Fatigue Syndrome
- Other ______________

ENT:
- Hearing loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other ____________

NEURO:
- Multiple Sclerosis
- Seizures/Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraines
- Other ____________

PSYCH:
- Depression
- Attention Deficit
- Anxiety/Panic disorder
- Bipolar disorder
- Other ______________

CARDIOVAS:
- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other _____________

RESPIRATORY:
- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea
- Other _____________

GASTROINTESTINAL:
- Crohn's
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease
- Other ____________

GENITOURINARY:
- Kidney disease
- Prostate disease/cancer
- STD (herpetic/chlamydia)
- Benign Prostate Hypertrophy
- Pregnant or Nursing
- Herpes
- Chlamydia
- Other ____________

MUSC/SKEL:
- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other _____________

INTEGUMENTARY (Skin):
- Eczema
- Rosacea
- Psoriasis
- Cold Sores
- Shingles
- Other _____________

ENDOCRINE:
- Type 2 diabetes
- Type 1 diabetes
- Thyroid dysfunction
- Hormonal dysfunction
- Other ______________

HEM/LYMPH:
- Anemia
- Large-volume blood loss
- Ulcer
- High Cholesterol
- Other ______________

ALLERGY/IMM:
- Drug allergies
- Environmental allergies
- Rheumatoid Arthritis
- Lupus
- Sjoren's Syndrome
- Other ____________

Doctor's Signature______________________________ Review Date _____________

Dr George Hertneky

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM