Holliston Vision Center

(INTERNAL USE ONLY: scanned / SOS)

Name: _____
Date of birth: _____ Sex: _ M _ F
Address: _____
City/State/Zip: _____
Tel: H (_____) _____ W (_____) _____
Social Security # _____
E-Mail _____ @ _____

Primary Care Physician: _____
Facility / location: _____

Reason for today's visit: _____
_____
Who may we thank for referring you? _____
_____

If you have a separate vision Plan from your Health Insurance , please Inform the Staff..

Health Assessment:
Do *you* have a history of the following health conditions?

Yes	**No**	
Y	N	Diabetes
Y	N	High blood pressure
Y	N	Cholesterol
Y	N	Thyroid Condition
Y	N	Heart condition
Y	N	Lung condition
Y	N	Allergies
Y	N	Arthritis
Y	N	AIDS/HIV

Please list all your current medications:
_____
_____
Drug allergies: _____

Do you smoke? ☐ Yes ____ packs per day
☐ No

Does anyone in your immediate *family* have a history of the following health conditions?

Yes	**No** (check the appropriate box)	
Y	N	Diabetes
Y	N	High blood pressure
Y	N	Glaucoma
Y	N	Thyroid condition
Y	N	Heart condition
Y	N	Lung condition
Y	N	Arthritis

Insurance Subscriber Information
Name _____
D.O.B. _____
Social Security # _____

Eye Assessment:
Have *you* ever had any of the following eye conditions?

Yes	**No**	
Y	N	Turned eye or lazy eye
Y	N	Eye surgery (Including LASIK)
Y	N	Eye injury
Y	N	Floaters or spots in vision
Y	N	Flashes of light in vision
Y	N	Double vision
Y	N	Eyes burn, itch or water
Y	N	Eye infection
Y	N	Glaucoma

Do you currently wear glasses? ☐ Yes ☐ No

When do you wear your glasses? (Check all that apply)
☐ All the time
☐ Distance vision only
☐ Reading/near work only
☐ Computer work
☐ Work safety
☐ After contact lens wear

*****For Contact Lens Wearers*****
Have you *ever* worn contact lenses? ☐ Yes ☐ No
Do you *currently* wear contact lenses? ☐ Yes ☐ No

If Known, Please list the type of contacts that you wear:
_____
_____

□ Please register me to order contact lenses online at **www.HollistonVisionCenter.com**. Registration does not oblige me to purchase contact lenses. I understand that my personal information and email address will be kept confidential.

Occupation: _____

Do you work at a computer or video display terminal?
☐ Yes ☐ No

What hobbies or sports do you participate in?
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I also understand that I am financially responsible for all charges whether or not paid by my insurance carrier.
Signature of patient (or parent if minor) _____ Date _____