Professional Vision Care
M.V. Johnston O.D. Optometrist
P.O. Box 270 Harlan, IA 51537 (712) 755-2150
Welcome to Our Office

Name _____
Social Security Number _____
Date of Birth _____
Address _____
City _____ State_____ Zip_____
Home Phone_____
Cell/Work Phone _____
Email Address _____
Occupation _____
Employer/School _____
Marital Status _____

***Insurance Information**
Name of Insured _____
Relationship to patient _____
Insurance Company _____
Member Number _____
Group Number _____
Secondary Insurance _____

***Responsible Party**
Name of person responsible for this account
_____
Social Security Number _____
Address_____
Phone_____
Employer _____
How will you settle this account today?
CASH CHECK CREDIT CARD

Patient Interests
Hobbies _____
Do you spend large amount of time outdoors?
YES NO
Do you spend large amounts of time at the computer? YES NO
Who is your family physician?
_____

Whom may we thank for referring you to our practice _____

Do you experience…
-Any discomfort with your eyes? _____
-Problems with glare of reflection? _____
-Sensitivity to light? _____
-Headaches? _____
-Floaters or Flashes of light? _____

Allergies	YES	NO	In My Family
Asthma	YES	NO	In My Family
Arthritis	YES	NO	In My Family
Cancer	YES	NO	In My Family
Eye Surgery	YES	NO	In My Family
Diabetes	YES	NO	In My Family
Glaucoma	YES	NO	In My Family
Eye Diseases	YES	NO	In My Family
Eye Injury	YES	NO	In My Family
Heart Disease	YES	NO	In My Family
High Blood Pressure	YES	NO	In My Family

Diagnostic Issues

Do you wear contacts?	YES	NO
Do you wear glasses?	YES	NO
Do you have any complaints about wearing glasses or contacts?	YES	NO
Glasses: How many RX pairs do you have _____		
Are there times that you would rather not wear glasses?	YES	NO
Contacts: Are you satisfied with vision and comfort?	YES	NO
Would you like to "test drive" the latest in contact lenses?	YES	NO

Drug allergies:_____
Other allergies: _____
Do you use Tobacco Products? YES NO
Please list current medications:_____
_____
_____
_____

Constitutional Systems:

Good General Health lately	Yes	No
Recent Weight Change	Yes	No
Loss of appetite	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Nausea/Vomiting	Yes	No

Respiratory:

Persistent cough	Yes	No
Shortness of breath	Yes	No
Tuberculosis	Yes	No
Wheezing	Yes	No
Spitting up blood	Yes	No

Ear /Nose / Throat / Mouth

Earaches or drainage	Yes	No
Sore Throat / Voice Change	Yes	No
Chronic sinus problem	Yes	No
Nose Bleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath / Bad taste	Yes	No
Hearing loss or injury	Yes	No

Neurological:

Head Injury	Yes	No
Numbness / tingling	Yes	No
Paralysis	Yes	No
Headaches	Yes	No
Light headed / dizzy	Yes	No
Convulsions / seizures	Yes	No
Tremors	Yes	No

Hematologic/Lymphatic:

Anemia	Yes	No
Bleeding/Bruising	Yes	No
Slow to heal after cut	Yes	No
Phlebitis	Yes	No
Past Transfusion	Yes	No
Enlarged gland	Yes	No

Psychiatric:

Memory loss	Yes	No
Confusion	Yes	No
Depression	Yes	No
Nervousness	Yes	No
Insomnia	Yes	No

Cardiovascular:

Heart Trouble	Yes	No
Chest pain / angina	Yes	No
Swelling	Yes	No

Musculoskeletal:

Joint pain	Yes	No
Joint stiffness	Yes	No
Muscle pain / cramp	Yes	No
Back pain	Yes	No
Cold extremities	Yes	No
Difficulty walking	Yes	No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It's my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient
Signature/Date _____

Signature/Date _____

Signature/Date _____

Patient
Signature/Date _____

Signature/Date _____

Signature/Date _____

For Dr's Use:

Pt orientated to person/place/time Yes No
HPI _____
_____
Dr's signature/Date _____

Pt orientated to person/place/time Yes No
HPI _____
_____
Dr's signature/Date _____

Pt orientated to person/place/time Yes No
HPI _____
_____
Dr's signature/Date _____

Pt orientated to person/place/time Yes No
HPI _____
_____
Dr's signature/Date _____

Pt orientated to person/place/time Yes No
HPI _____
_____
Dr's signature/Date _____

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HPI _____
_____
Dr's signature/Date _____