



Welcome Back to ABC Vision Source  
 Sherwood  
 Dr. Mari Ward & Dr. Suzanne Zamberlan

**RETURN Patient Information (All information will be Confidential)**

Patient \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_ E-mail address \_\_\_\_\_  
**Reason for today's visit** \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

**Insurance Information**

**VISION**

**MEDICAL**

S. S. # \_\_\_\_\_ Insurance Co. Name \_\_\_\_\_  
 Name of insurance co. \_\_\_\_\_ Name of insured \_\_\_\_\_  
 ID/Policy/Group# \_\_\_\_\_ ID/Policy/Group# \_\_\_\_\_

**DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL?**  **yes**  **no**

**Visual Information**

Please check all that you are experiencing with your current correction:  **No change**

- |  |  |   |  |
|--|--|---|--|
| <b>Yes</b>                             | <b>Yes</b>                                 | <b>Yes</b>                                      | <b>Yes</b>   |
| <input type="checkbox"/> Blur far away | <input type="checkbox"/> Eyes itch         | <input type="checkbox"/> Discharge from eyes    | <input type="checkbox"/> Reading held at 10" or less |
| <input type="checkbox"/> Blur up close | <input type="checkbox"/> Eyes water easily | <input type="checkbox"/> Light sensitivity      | <input type="checkbox"/> Double vision               |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Dry eyes          | <input type="checkbox"/> Pain in or around eyes | <input type="checkbox"/> Eyes burn                   |
| <input type="checkbox"/> Squinting     | <input type="checkbox"/> Floaters or spots | <input type="checkbox"/> Eye strain/tired eyes  | <input type="checkbox"/> Night vision problems       |

Have you had any eye injury, infection or surgery?  yes  no Explain \_\_\_\_\_

**Lifestyle Factors! Your answers will assist us in selecting the best eyewear for you!**

Occupation \_\_\_\_\_ Spouses' Occupation \_\_\_\_\_

Are you required to wear safety glasses at work?  yes  no

Do you work at a computer or video display terminal?  yes  no

What hobbies, social activities or sports do you participate in? \_\_\_\_\_

Are you tired of wearing glasses and interested in contacts?  yes  no

Are you interested in getting updated glasses?  yes  no

Do you have a back-up pair of glasses available?  yes  no

Do you have prescription sunglasses?  yes  no

Does road glare bother you?  yes  no

Do you use any of the following on a regular basis: \_\_\_ Tobacco \_\_\_ Alcohol \_\_\_ Other Substances

**Health Information**

Please list any **NEW** medications you are taking and their purpose: \_\_\_\_\_

Have you had any **NEW** changes in your health or any major health problems?  yes  no  **No change**

Do you or does anyone in your family have a history of:

- | <b>Self</b>              | <b>Family</b>            |                     | <b>Self</b>              | <b>Family</b>            |              | <b>Self</b>              | <b>Family</b>            |                                   |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis    | <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia (lazy eye)              |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease       | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy     | <input type="checkbox"/> | <input type="checkbox"/> | Eye Disease                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke              | <input type="checkbox"/> | <input type="checkbox"/> | Cancer       | <input type="checkbox"/> | <input type="checkbox"/> | Cataract                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Allergies/Hay Fever               |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems    | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma     | <input type="checkbox"/> | <input type="checkbox"/> | Strabismus (crossed or wall eyes) |

Do you use any of the following on a regular basis: \_\_\_ Tobacco \_\_\_ Alcohol \_\_\_ Other Substances

Are you allergic to any medications?  yes  no Please list \_\_\_\_\_

**Authorization** - I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X \_\_\_\_\_  
 Signature of Patient (Or parent if a minor) Date Doctor Initials/Date