ANGELES VISION CLINIC

Dr. Kirk Thompson / Dr. Thomas Reis
Dr. Eric Van Orman
OPTOMETRIC PHYSICIANS
Board Certified ABO
Visit us at www.avclinic.com

PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name_____ DOB_____ Today's Date _____

Street Address _____City_____ Zip Code _____

Home Phone _____ Work Phone_____Marital Status _____

Would you prefer to be contacted by e-mail? No Yes e-mail _____

Insurance _____ Occupation _____

Subscriber _____ Employer _____

ID# _____ Physician _____

Referred By _____ S.S. number_____

1) Do you have any of the following conditions?

- ☐ Diabetes
- ☐ Sarcoidosis
- ☐ Leukemia
- ☐ Bleeding disorder
- ☐ Asthma
- ☐ Temporal Arteritis
- ☐ Tuberculosis
- ☐ Lupus
- ☐ Seizures
- ☐ Digestive Problems
- ☐ Heart conditions
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ MS
- ☐ Syphilis
- ☐ Pregnant
- ☐ High blood pressure
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Shortness of breath
- ☐ Shingles
- ☐ Arthritis
- ☐ Crohn's Disease

Any other medical conditions: _____

2) Do you have a family history of the following?

- ☐ Diabetes
- ☐ Cataracts
- ☐ Retinal detachments
- ☐ Blindness
- ☐ Glaucoma
- ☐ Severe headaches
- ☐ Turned or lazy eye
- ☐ Macular Degeneration
- ☐ Heart Conditions

3) Have you ever had any of the following eye symptoms / Conditions?

- ☐ Cataracts
- ☐ Eye infections
- ☐ Glaucoma
- ☐ Turned or lazy eye
- ☐ Iritis / Uveitis
- ☐ Retinal detachments
- ☐ Sensitivity to light
- ☐ Floaters or spots
- ☐ Watery eye
- ☐ Color deficiency
- ☐ Eye pain
- ☐ Macular Degeneration
- ☐ Dry eye
- ☐ Burning or itching
- ☐ Corneal ulcers
- ☐ Blindness
- ☐ Numbness
- ☐ Herpes Simplex

4) Do you have any of the following Vision Symptoms?

- ☐ Double vision
- ☐ Eye strain
- ☐ Poor near vision
- ☐ Poor distance vision
- ☐ Tunnel vision

5) History of Past Eye surgery: yes no

- ☐ Cataract
- ☐ Macular degeneration
- ☐ Lid Surgery
- ☐ Refractive Surgery
- ☐ Ocular tumors
- ☐ Tear duct
- ☐ Retinal Detachment
- ☐ Ocular trauma
- ☐ Cosmetic

7) Please list all the prescription medications and supplements you are currently taking:

_____

_____

8) List any drug allergies: _____

_____

9) Do you currently wear glasses? Yes No

- ☐ All the time
- ☐ Part time
- ☐ Distance only
- ☐ Reading only
- ☐ Computer work
- ☐ Other

10) Have you ever worn contact lenses? Yes No

- ☐ Soft
- ☐ Gas Perm
- ☐ Multi Focal
- ☐ Daily wear
- ☐ Extended wear
- ☐ Mono Vision
- ☐ Astigmatic
- ☐ Tinted

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

12) Are you interested or would you like to receive information on refractive Surgery? Yes No

13) Has anyone in your family been in before? Yes No

Angeles Vision Clinic

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Kirk Thompson, O.D. Thomas P Reis, O.D. Eric Van Orman, O.D.

NOTICE OF PRIVACY PRACTICES ~ ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and to copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. If you wish to see your record or get more information about it, please contact Tammy Matthews, Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your information may be used and disclosed, and how you can access your information. You may request a copy of the Privacy Practices at any time by contacting Tammy Matthews, Office Manager.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of patient Relationship to patient

This form will be retained in your medical record.