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Welcome Back to Our Office

In order to keep your medical file up-to-date, please complete this page. Thank You!

Title: Dr. / Mr. / Mrs. / Ms. /Master /Miss / Rev. / Judge

Name:_______________________________________

Home address:_______________________________

City:_____________ State: ____ Zip: _______________

Home phone: (________)_________________________

Work phone: (________)_________________________

Cell phone: (________)_________________________

E-mail address: ______________________________

Today's date: ______________________________

Date of Birth: _______________ Age: __________

Social Security #/School ID #: _________________

Employer (or School): _________________________

Occupation (or Grade): _______________________

Status: Married / Divorced / Single / Widow(er)

Have you visited us on the Internet? Y N

www.visionsource-summit.com

Updated Health Information

Vision Insurance: ___________________________

Medical Insurance: ___________________________

Type: PPO / POS / HMO / Medicare Part B / Other: _______

Do you participate in a Flexible Spending Account? Yes / No

Family Physician/Internist Name: _____________________

Date of Last Visit: _______________

Allergies to Medications: __________________________

Are you planning on getting new glasses today? Yes / No / If there is a change

Are you interested in contact lenses today? Yes / No

Are you interested in being notified through text for appointments? Yes/No

Personal Medical History/Current Medications:

Allergies:_______________________________________

Arthritis: _______________________________________

Cholesterol: _____________________________________

Diabetes: _______________________________________

Eye Injury/Disease: _______________________________

Heart: ____

High Blood Pressure: ______________________________

Surgery: ____

Other(s)____

Females: Are you currently pregnant or breastfeeding? Yes / No

Are you experiencing any of the following symptoms?

- ☐ Blurry Vision
- ☐ Dizziness
- ☐ Double Vision
- ☐ Dry Eye(s)
- ☐ Flashing Lights
- ☐ Floaters / Spots
- ☐ Glare / Halos
- ☐ Grittiness /Sandy
- ☐ Headaches
- ☐ Itchy Eye(s)
- ☐ Light Sensitivity (Photophobia)
- ☐ Red Eye(s)
- ☐ Stinging / Burning
- ☐ Stye
- ☐ Tearing / Teary eye(s)
- ☐ Trouble seeing while driving

Family Medical History:

Blindness	Yes / No / Unsure
Cataracts	Yes / No / Unsure
Diabetes	Yes / No / Unsure
Glaucoma	Yes / No / Unsure
High Blood Pressure	Yes / No / Unsure
Macular Degeneration	Yes / No / Unsure

Other disease(s): ______________________________

I acknowledge that I have received a copy of Dr. Justin T. Abo & Dr. Lauren A. Abo's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.visionsource-summit.com.

Patient name ____________________________________ Today's Date ___________________________

Signature of patient (or parent/guardian for minors) ____

Thank you!

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