Virginia Beach Eye Center
CLEAR VISION FOR A LIFETIME

**Welcome to Virginia Beach Eye Center!**

Please assist us in our effort to serve you better by filling out this brief questionnaire. It gives us valuable information about your health and is required by your insurance company!

Name (Last, First, MI) _____ Date of Birth _____ Age _____

Address _____City _____ State _____Zip _____

Telephone (Home) _____ (Cell) _____ (Work) _____ Gender M F

Ethnicity _____ Email _____ SSN _____ - ____ - _____

Employer _____ Occupation _____

Spouse Name (Parent, If Patient Is Minor) _____

Address (If Different From Above) _____

Spouse/Parent SSN _____ - ____ - _____ DOB _____ Telephone _____

Insurance Company _____ Policy # _____ Policy Holder_____

Are you being seen for a work related injury? Y N If yes, date of injury _____

**Social History:**

| | No | Yes, please specify (if applicable) |
|---|---|---|
| Do you smoke?<br>If so, # packs/day | | |
| Are you a former smoker? | | |
| Do you drink alcohol?<br>If so, how often? | | |
| Do you use IV or recreational drug use? | | |

**Eye History:**

Are you experiencing any of the following ocular symptoms?

Floaters ☐ Flashes ☐ Blurred Vision ☐ Redness ☐ Itching ☐ Burning ☐

Tearing ☐ Dryness ☐ Pain ☐ Light Sensitivity ☐ Difficulty Reading ☐

Have you had any prior **eye** surgeries? If yes, please specify type of surgery, eye and date of surgery. _____

_____

**Eye History (Continued):**

| Condition | Self, please specify if applicable | Family, please specify family member |
|---|---|---|
| Glaucoma | | |
| Cataracts | | |
| Macular Degeneration | | |
| Retinal Detachment | | |
| Lazy Eye (Amblyopia) | | |
| Blindness | | |
| Other (specify) | | |

**Medical History:**

| Condition | No | Yes | Specify if 'yes' |
|---|---|---|---|
| Diabetes | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Cardiovascular/Heart | | | |
| Lung/Asthma | | | |
| Thyroid | | | |
| Muscle/Joint | | | |
| Immunologic | | | |
| Neurological | | | |
| Cancer | | | |
| Anxiety/Depression | | | |
| Allergies | | | |
| Skin Condition | | | |
| Kidney/Bladder | | | |
| Hepatitis/HIV/AIDS/TB | | | |
| Stomach/Bowel | | | |
| Ear/Nose/Throat | | | |
| Pregnant/Nursing | | | |
| Other (Specify) | | | |

Please list all prior **general** surgeries you have had. _____

_____

Have you received a flu vaccine this year? Y N

Have you had a pneumonia vaccine within the last 5 years? Y N

**Current Medications:**

| Name of Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |

**Drug Allergies:**

| Drug/Medication | Reaction | Severity (Mild, Moderate, Severe) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Pharmacy Information:**

Pharmacy Name _____ Location/Address _____

**Other Medical Doctors:**

Primary Care Physician _____ Other (Endocrinologist, Rheumatologist, etc.) _____

# REFRACTION AND YOUR EYEGLASS PRESCRIPTION

A refraction test is more than just the diagnostic test performed to determine your need for glasses or contacts. **It is not dilation. It provides your physician with information** regarding the health of your eyes and whether they are functioning properly, including the detection of vision loss.

- Refraction testing is necessary for a patient to receive a prescription for glasses or contact lenses.
- Many insurance plans, including Medicare, **do not cover this service**.
- The charge for a refraction test is **$55.00**. Payment is due at the time of service.
- Eyeglass/contact lens prescriptions expire **1 year** from the date of the exam.
- If the date on your eyeglass prescription is less than 90 days and you had a refraction test at our office, we will be happy to re-check your prescription at no charge. If the prescription is older than 90 days, there will be an additional charge to re-check your refraction.

_____**YES** I would like to have a refraction test performed today. I understand that there is a $55.00 fee for this service.

_____**NO** I would not like to have a refraction test today. I understand that I will not receive an eyeglass prescription.

_____ _____

**Patient Signature** **Date**