North Valley Eye Care, P.C. • Dr. Justin L. Kohls • Dr. Michelle A. Kohls

New Patient History Form

Name:____ Nickname:___________________ **Age:**_____ **Date of Birth:**____/____/_____

If child, Name of Parent(s):_______________________________ **Email Address:**____

Address:____ **City:**________________________ **Zip:**________________

Home Phone:______________________ **Daytime Phone:**_______________________ **Cell Phone:** ______________________________

Employer/Occupation:_______________________________________ **Hobbies/Interests:**______________________________________

Preferred language? ☐ English ☐ Spanish **Ethnicity?** ☐ Hispanic or Latino ☐ Native Hawaiian/ Pacific Islander ☐ Not Hispanic or Latino

Race? ☐ White ☐ Hispanic ☐ Black or African American ☐ Asian ☐ American Indian ☐ Native Hawaiian

How did you hear about our office? ☐ Saw our sign ☐ Insurance Website ☐ Postcard ☐ Yellow Pages ☐ Referral by friend or family If so,

Name of person who referred you here? ______________________ and relationship to you?________________ ☐ Other________________

Name of **Vision Insurance** or ☐ None ____

Name of primary person on Vision Plan or ☐ Self______________________________ Primary Insured's Employer:_______________________

Name of **Medical Insurance** or ☐ None ____________________________________ Primary Care Doctor's Name:______________________

Name of primary person on Medical Plan or ☐ Self___________________________ Primary Insured's Date of Birth:______/______/______

If using *Medicare,* please provide your Social Security Number: ___________________________

Visual and Medical History

Date of last eye exam:_________________ **By whom?:**_______________________

Date of last physical exam:________________ **Height:** _______ **Weight:**_______ **Last Blood Pressure Reading:** _______/_______

What type of exam are you here for? ☐ Spectacle exam ☐ Contact lens exam ☐ Both ☐ Medical Eye Visit

Do you presently wear? ☐ Eyeglasses ☐ Sunglasses **What type?** ☐ Single Vision ☐ Progressive ☐ Lined Bifocal

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, which brand?_____________________☐ Don't know

Have you ever worn contact lenses? ☐ Yes ☐ No **If No, are you interested in trying contact lenses?** ☐ Yes ☐ No

Please check any symptoms you are currently experiencing: ☐ None

Vision Complaints	**Ocular Symptoms**
☐ Blurred Vision at Distance ☐ w/ Glasses ☐ **w/** Contacts or ☐ w/out correction ☐ Blurred Vision at Near ☐ w/ Glasses ☐ **w/** Contacts or ☐ w/out correction ☐ Blurred Vision at Computer ☐ w/ Glasses ☐ **w/** Contacts or ☐ w/out correction	☐ Pain ☐ Foreign body sensation ☐ Dry/sandy feeling ☐ Some redness ☐ Extreme redness ☐ Burning ☐ Itching ☐Eyelid Swollen ☐ Eyelid crusty ☐ Watery eye ☐ Lids stuck together upon awakening ☐ Mucous-like discharge ☐ Eyelid twitching ☐ Other concerns:____ **Which eye is affected?** ☐ Right Eye ☐ Left Eye ☐ Both Eyes **What pharmacy do you prefer? Please list the major cross streets.** ____

Personal Eye History ☐ Cataracts ☐ Glaucoma ☐ Retinal Detachment ☐ Loss of Vision ☐ Macular Degeneration ☐ Lazy Eye ☐ Head or Eye Injury

☐ Dry Eye Syndrome ☐ Other ____

Eye Medications (Please list all drops including over-the-counter) ____

Eye Surgery ☐ Cataract ☐ Refractive ☐ Eye Muscle Surgery ☐ Other____

Medications ____

Allergies to medications____

Social History for Adults

Alcohol Use? ☐ None ☐ Social Use Only ☐ 1-2 drinks daily ☐ Above average use ☐ Alcohol Dependence

Tobacco Use? ☐ Never Smoked ☐ Former Smoker ☐ Light Smoker (1-9 cigs/day) ☐ Every day Smoker

☐ Heavy Tobacco smoker ☐ Smokeless tobacco user

Narcotic Use? ☐ None ☐ Recreational Use ☐ Chemical Dependence

Review of Systems: Please indicate any condition that applies to you with a check mark. ☐ **NONE**

Cardiovascular	Immunologic	Neurological
☐ High Blood Pressure	☐ Rheumatoid arthritis	☐ Headaches
☐ High Cholesterol	☐ Lupus	☐ Multiple Sclerosis
☐ Heart Attack	☐ Sjogren's Syndrome	☐ Myasthenia Gravis
☐ Pacemaker	☐ Histoplasmosis	**Psychiatric**
Constitutional	**Integumentary/Skin**	☐ Depression
☐ Dizziness	☐ Eczema	☐ Panic Disorder/Schizophrenia
☐ Excess Thirst	☐ Rosacea	☐ Drug Dependence
☐ Excess Urination	☐ Psoriasis	**Respiratory**
☐ Weight Gain / Weight Loss	☐ Skin Cancer	☐ Asthma
Endocrine	**Liver / Lymph System**	☐ COPD
☐ Diabetes	☐ Anemia	☐ Lung Cancer
☐ Thyroid Dysfunction	☐ Leukemia	☐ Sarcoidosis
☐ Pituitary Dysfunction	**Musculoskeletal**	**Other:**
Gastrointestinal	☐ Arthritis	____________________________
☐ Crohn's Disease	☐ Fibromyalgia	____________________________
☐ Hepatitis		

Family History: ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems ☐ Cancer

Please specify whom____

Family Eye History: ☐ Cataracts ☐ Glaucoma ☐ Retinal Detachment ☐ Macular Degeneration ☐ Eye Surgery ☐ Lazy Eye ☐ Other

Please specify whom____

For Contact Lens Wearers…

Contact lens evaluation and fitting:

Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. Contact lenses are medical devices and even though they may feel fine, there are health risks that must be taken seriously. In order to renew your contact lens prescription, your doctor performs the following tests on a yearly basis. These procedures are not part of a standard eye exam.

- Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
- Slit lamp microscope examination of the cornea, conjunctiva and eyelid tissues, to check the eye health and to look for adverse effects from contact lens wear.
- Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions).
- We also review new lens designs, materials and cleaning solutions that may improve comfort and/or health.

Some insurances may cover some of the cost of the contact lens evaluation fee. If you have never worn contact lenses, there is an additional training fee. Contact lens fittings start at $71.

For All Patients…

Acknowledgement of HIPAA Policies:

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature____ Date______/______/______

Acknowledgement of Financial Policies:

I hereby authorize North Valley Eye Care, P.C. to release information that is required by my insurance carrier.
I acknowledge that I am financially responsible for all non-covered charges.

Signature____Date______/______/_____