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 ☐ Social Media ☐ 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 Medicare 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

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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

Vision Complaints: **Please check any vision complaints or** ☐ None

☐ 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

For School-Aged Patients… Are there any challenges with reading and /or learning? Please explain._____

_____

Ocular Health Symptoms:

Please check ocular health symptoms or ☐ None

Which eye is affected?
☐ Right Eye
☐ Left Eye
☐ Both Eyes affected

Ocular Symptoms you currently have?
☐ Pain
☐ Pressure feeling
☐ Foreign body sensation
☐ Dry/sandy feeling
☐ Some redness
☐ Extreme redness
☐ Burning
☐ Itching
☐ Eyelid swollen
☐ Eyelid droopy
☐ Eyelid crusty
☐ Watery eye
☐ Lids stuck together upon awakening
☐ Increased light sensitivity
☐ Mucous-like discharge
☐ Eyelid twitching
Other symptoms:_____

Onset of Ocular Health Symptoms?
☐ Today
☐ Yesterday
☐ Mornings
☐ Evenings
☐ As the day wears on
☐ Recently (in last 7 days)
☐ Increased over time

Duration Ocular Health Symptoms?
☐ One time only
☐ Comes and goes
☐ Persistent
☐ Seasonal

Severity Ocular Health Symptoms?
☐ Mild
☐ Bothersome
☐ Very bothersome
☐ Lessening
☐ Remaining the same
☐ Increasing

Context Ocular Health Symptoms?
☐ No known cause
☐ Worse in right eye
☐ Worse in left eye
☐ Both eyes affected
☐ Post-trauma relationship
Please Explain:_____

Eye Medications (Please list all used recently, including over-the-counter) _____
_____

Have you seen another provider for this eye health condition? ☐ No ☐ Yes **If yes, please explain.**
_____
_____
_____

What pharmacy do you prefer? Please list the cross streets. _____

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

Cardiovascular
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Attack
☐ Pacemaker

Constitutional
☐ Dizziness
☐ Excess Thirst
☐ Excess Urination
☐ Weight Gain / Weight Loss

Endocrine
☐ Diabetes
☐ Thyroid Dysfunction
☐ Pituitary Dysfunction

Gastrointestinal
☐ Crohn's Disease
☐ Hepatitis

Immunologic
☐ Rheumatoid arthritis
☐ Lupus
☐ Sjogren's Syndrome
☐ Histoplasmosis

Integumentary/Skin
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Skin Cancer

Liver / Lymph System
☐ Anemia
☐ Leukemia

Musculoskeletal
☐ Arthritis
☐ Fibromyalgia

Neurological
☐ Headaches
☐ Multiple Sclerosis
☐ Myasthenia Gravis

Psychiatric
☐ Depression
☐ Panic Disorder/Schizophrenia
☐ Drug Dependence

Respiratory
☐ Asthma
☐ COPD
☐ Lung Cancer
☐ Sarcoidosis

Other:
_____
_____

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…

Annual 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.

Your vision insurance may claim to pay for your contact lens fitting, but in this case they always subtract the fitting amount from your contact lens material allowance. When you pay for the contact lens fitting today, you will have your entire contact lens allowance for the purchase of contact lenses (or for glasses lenses if you decide at any time not to purchase contact lenses).
If you have never worn contact lenses, there is an additional training fee of $35.
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 including annual contact lens fitting fees.

Signature_____Date_____/_____/_____