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:**_____

How did you hear about our office? ☐ Saw our sign ☐ Insurance Website ☐ Social Media ☐ Referral by friend or family and

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: _____

Eye Health and Vision History

Date of last eye exam:_____ **By whom?**_____

Date of last physical exam:_____ **Primary Care Doctor:**_____ **Last Blood Pressure Reading:** _____/_____

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

Do you presently wear? ☐ Eyeglasses ☐ Sunglasses ☐ Contact lenses, which brand?_____☐ Don't know

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

Eye Surgery ☐ Cataract ☐ Lasik ☐ RK ☐ Eye Muscle Surgery ☐ Other _____

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

Vision Complaints: Please check any vision complaints or mark ☐ 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 Complaints

or mark ☐ None

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

Current Symptoms?
☐ Pain
☐ 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 discharge
☐ Eyelid twitching

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

Duration?
☐ One time only
☐ Comes and goes
☐ Persistent
☐ Seasonal

Severity?
☐ Mild
☐ Bothersome
☐ Lessening
☐ Stays the same
☐ Worsening

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

Eye Medications/Treatments
(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.
_____
_____
_____

Medical History: Please check any condition that applies to you or mark ☐ NONE

Cardiovascular
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Attack
☐ Other _____
Constitutional
☐ Dizziness
☐ Excess Thirst or ☐ Urination
☐ Weight Gain / Weight Loss
Endocrine
☐ Diabetes
☐ Thyroid Dysfunction
☐ Pituitary Dysfunction

Gastrointestinal
☐ Crohn's Disease
☐ Hepatitis
Immunologic
☐ Rheumatoid arthritis
☐ Lupus
☐ Sjogren's Syndrome
☐ Other_____
_____
Integumentary/Skin
☐ Eczema or ☐ Psoriasis
☐ Rosacea
☐ Skin Cancer

Liver / Lymph System
☐ Anemia
☐ Leukemia
Musculoskeletal
☐ Arthritis
☐ Fibromyalgia
☐ Other_____
Neurological
☐ Headaches
☐ Multiple Sclerosis
☐ Stroke
☐ Seizures
☐ Other_____
_____

Psychiatric
☐ Depression
☐ Panic Disorder/Schizophrenia
☐ Drug Dependence

Respiratory
☐ Asthma
☐ COPD
☐ Lung Cancer
☐ Sarcoidosis
☐ Sleep Apnea
Other:_____
_____
_____

List all medications:_____

Medical Allergies:_____

Tobacco Use? ☐ Every day smoker ☐ Light smoker (1-9 cigarettes/day) ☐ Former smoker ☐ Never smoked

Alcohol Use? ☐ None ☐ Less than 1-2 drinks per day ☐ 1-2 drinks daily ☐ 3 or more drinks per day ☐ Alcohol dependence

Caffeine Use? ☐ Several times a day ☐ Once per day ☐ A few times per week ☐ Never

Family History: ☐ Diabetes ☐ High Blood Pressure - Please specify who: ☐ Mother ☐ Father ☐ Sibling ☐ Aunt ☐ Uncle ☐ Grandparent

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

Please specify who: ☐ Mother ☐ Father ☐ Sibling ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Child

Optomap Wide-field "Manaco" Retinal Imaging and Tomography

We use the industry's best and newest "Optos Monaco" to help evaluate your retinal health. This is the most important part of everyone's annual eye exam and will be performed at least yearly on all of our patients to help give the very best exam possible. Patients age 60 and older will also receive an OCT (tomography) screening which further assists in analyzing each individual layer of the retina and macula. The Optos Monaco screening is $39.

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.

If you have never worn contact lenses, there is an additional training fee of $35. Contact lens fittings start at $60.

For Contact Lens Wearers…

I acknowledge that I am responsible for paying for the contact lens fitting and per new FTC guidelines, I am also acknowledging that I received a copy of my contact lens prescription at the completion of the contact lens fitting and prescribing process.
If you need printed copies of your prescription, we can also fax or mail them to you at your request.

Signature_____ Date_____/_____/_____

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_____/_____/____