

## WELCOME & REASON FOR VISIT (RFV) FORM

Welcome to our office! We appreciate the opportunity to care for your vision and eye health today. Please read and complete the following forms so that we can better understand your current symptoms, your health history, and your lifestyle...so we can best serve your vision care and eyewear needs. Thank you.

If you are a new patient, how did you choose our office today?

- Insurance provider list
- Website
- Mailer &/or magnet
- Yellow pages
- Recommended by  family  friend/neighbor  co-worker  healthcare provider.

Your comprehensive annual eye examination today will typically take between 1 hour and 1 1/2 hours. This includes vision tests to determine the refractive state of your eyes for eyeglasses and a thorough health check of your eyes for cataracts, glaucoma, and retinal disease.

How long has it been since your last comprehensive annual eye examination?

- Date, if known \_\_\_/\_\_\_/\_\_\_
- 1 year or less    2 years    3 years    4 years    5+ years
- This is my first comprehensive eye exam with an eye doctor.

Have you recently failed a vision screening?

- No.
- Yes, at school.    Yes, my driver's test.    Yes, a community screening.    Yes, at my doctor's office.

In addition to your comprehensive eye examination described above, are you interested in being fitted or refitted for contact lenses today?

- Yes. I am interested in being fitted or refitted for contact lenses today.
- Maybe. I would like to discuss my options for wearing contact lenses with the doctor.
- No. I have no desire to be fit for contact lenses today.

Are you interested in discussing your options for refractive surgery (such as LASIK) today?

- Yes. I am interested in proceeding with refractive surgery as soon as possible.
- Maybe. I would like some additional information about my refractive surgery options.
- No. I have no desire to have refractive surgery.

Next, please complete the PRESENTING SYMPTOMS form on the reverse. You should also complete the PATIENT HISTORY form if you are a new patient or if you are an established patient who has not had a comprehensive annual eye exam since September 1, 2005 when we initiated our electronic medical records.

Then, return those two forms to the front desk, and allow the receptionist on duty to copy your current vision and major medical insurance cards. The receptionist will then give you copies of the HIPPA & OFFICE POLICIES form and the OPTOMAP RETINAL EXAM form for your review and consent.

*We empathize with you regarding the heavy amount of paperwork required to meet insurance companies' and federal agencies' standards today. We sincerely thank you for your understanding and assistance.*

Patient's Name (print):		Date of service (DOS):	
Date of birth (DOB):	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> New <input type="checkbox"/> Established

## PRESENTING SYMPTOMS (HPI/CHIEF COMPLAINT) FORM

Now, what brought you to see us today? What is your primary concern with your vision or your eyes today?  
(Please describe.)

Please check any of the following symptoms of blurred vision that you are experiencing [Acuity (Blur)]:

- I have not noticed any difficulties with blurred vision.
- My vision may have possibly changed, but any difficulties are not problematic.
- There is a noticeable decline or blur in my vision.

Please check any of the following visual symptoms that you are currently experiencing [Symptoms: Visual]:

- |   |   |
|---|---|
| <input type="checkbox"/> Asthenopia (eye strain)                              | <input type="checkbox"/> Skips lines                            |
| <input type="checkbox"/> General Headaches                                    | <input type="checkbox"/> Covers one eye reading                 |
| <input type="checkbox"/> Visual Headaches                                     | <input type="checkbox"/> Letter reversals                       |
| <input type="checkbox"/> Ocular (eye) fatigue                                 | <input type="checkbox"/> Head tilt                              |
| <input type="checkbox"/> Short reading span                                   | <input type="checkbox"/> Color difficulties                     |
| <input type="checkbox"/> Print moves / eyes drift                             | <input type="checkbox"/> Poor posture                           |
| <input type="checkbox"/> Jerky eye movements                                  | <input type="checkbox"/> Poor depth perception                  |
| <input type="checkbox"/> Print moved further away                             | <input type="checkbox"/> Bumps into objects                     |
| <input type="checkbox"/> Slow focus recovery                                  | <input type="checkbox"/> Squinting                              |
| <input type="checkbox"/> Loss of place reading                                | <input type="checkbox"/> Glare                                  |
| <input type="checkbox"/> Loss of concentration                                | <input type="checkbox"/> Sensitivity to light                   |
| <input type="checkbox"/> Poor achievement at school or work                   | <input type="checkbox"/> Night blindness                        |
| <input type="checkbox"/> Poor eye-hand coordination                           | <input type="checkbox"/> Halos around objects                   |
| <input type="checkbox"/> Misreads words                                       | <input type="checkbox"/> Doubling of vision                     |
| <input type="checkbox"/> Reads close  | <input type="checkbox"/> Floating spots and/or flashes of light |
| <input type="checkbox"/> Describe any other visual symptoms not listed above: |   |

Please check any of the following ocular (eye) symptoms that you are currently experiencing [Symptoms: Ocular]:

- |   |  |
|---|--|
| <input type="checkbox"/> Eye fatigue  | <input type="checkbox"/> Eyelids puffy                     |
| <input type="checkbox"/> Soreness   | <input type="checkbox"/> Eyelids swollen                   |
| <input type="checkbox"/> Pain   | <input type="checkbox"/> Eyelids droopy                    |
| <input type="checkbox"/> Heavy feeling  | <input type="checkbox"/> Eyelids baggy                     |
| <input type="checkbox"/> Pressure feeling   | <input type="checkbox"/> Eyelids crusty                    |
| <input type="checkbox"/> Ocular hemorrhage (eye bleeding)                           | <input type="checkbox"/> Watery eyes                       |
| <input type="checkbox"/> Foreign body sensation                                     | <input type="checkbox"/> Eyelids stuck together in morning |
| <input type="checkbox"/> Dry / sandy feeling  | <input type="checkbox"/> Rubs eyes                         |
| <input type="checkbox"/> Redness, some  | <input type="checkbox"/> Mucous-like discharge             |
| <input type="checkbox"/> Redness, extreme   | <input type="checkbox"/> Filmly-milky discharge            |
| <input type="checkbox"/> Burning, some  | <input type="checkbox"/> Infection                         |
| <input type="checkbox"/> Burning, extreme   | <input type="checkbox"/> Squinting                         |
| <input type="checkbox"/> Itching, some  | <input type="checkbox"/> Blinking                          |
| <input type="checkbox"/> Itching, extreme   | <input type="checkbox"/> Twitching                         |
| <input type="checkbox"/> Puffy, swollen, droopy, baggy, or crusty eyelids           | <input type="checkbox"/> Car/motion sickness               |
| <input type="checkbox"/> Describe any other ocular (eye) symptoms not listed above: |  |

Patient or guardian signature \_\_\_\_\_

Date \_\_\_\_\_