BOGHOSSIAN VISION

## PATIENT DEMOGRAPHICS

Name: ______________________________ ________________ __________
Last First Middle

Date of Birth: ___________________

Address: ____________________________________________________________________

____________________________________________________________________

Home Phone: _________________________

Cell Phone: _________________________

Email Address: _________________________

Employer: _________________________ Occupation: _________________________

Emergency Contact: _____________________ Phone: _________________________

**How did you hear about us?** (Please choose as many as applicable)

☐ Family/Friend ___________________
☐ Internet Search
☐ Yelp.com
☐ Vision / Health Insurance
☐ Building Sign
☐ Other _________________

**Insurance Information**

Health Insurance ☐ Yes ☐ No. Health Insurance Name: ___________________________

Vision Insurance ☐ Yes ☐ No. Vision Insurance Name: ___________________________

Primary Insured Name: _________________________ Date of Birth: ______________________

**VSP Only**: Primary Insured Last 4 Digit of Social Security Number ___________________

**I have been informed of the Notice of Privacy Practices and have received a copy.**

_____________________________________ _________________
Signature of Patient Date

**Initial**

____ **I give permission to Boghossian Vision to contact me for by text, phone and email.**

**PATIENT HEALTH HISTORY**

**Reason for Visit:** ☐ General Eye Exam
☐ Laser Vision Consultation
☐ Other ___________________________________________

| **Ocular History** | Self History | Family History |
|---|---|---|
| Keratoconus | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Pellucid Margin | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dry Eyes | ☐ Yes ☐ No | ☐ Yes ☐ No |
| History of herpes eye | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Amblyopia/Lazy Eye | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Fuch's Dystrophy | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Avellino Corneal Dystrophy | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Sjogren's Disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Recurrent Corneal Erosion | ☐ Yes ☐ No | ☐ Yes ☐ No |
| History of Eye Infections | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Eye Injury/Trauma | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Corneal Scar | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Glaucoma | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Macular Degeneration | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Other _________________ | | |

**Surgical History**

**Eye Surgery History** ☐ Yes ☐ No
If yes, please list: _________________________

**General Surgery History** ☐ Yes ☐ No
If yes, please list: _________________________

**Family Eye Surgery History** ☐ Yes ☐ No
If yes, please list: _________________________

| **Medical History** | | |
|---|---|---|
| Anxiety | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Autoimmune Dis. | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No |
| Bipolar | ☐ Yes | ☐ No |
| Collagen Vascular Dis. | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Heart Disease | ☐ Yes | ☐ No |
| Hepatitis | ☐ Yes | ☐ No |
| High Cholesterol | ☐ Yes | ☐ No |
| HIV | ☐ Yes | ☐ No |
| Hypertension | ☐ Yes | ☐ No |
| Keloids | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No |
| Lupus | ☐ Yes | ☐ No |
| Migraines | ☐ Yes | ☐ No |
| Multiple Sclerosis | ☐ Yes | ☐ No |
| Osteoarthritis | ☐ Yes | ☐ No |
| Rosacea | ☐ Yes | ☐ No |
| Rheumatoid | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Seasonal Allergy | ☐ Yes | ☐ No |
| Thyroid Disease | ☐ Yes | ☐ No |
| Other _________________________ | | |

**Medications:** ☐ Yes ☐ No
If yes, please list name and dosage: ______________________________________________________________________

**Medication allergies?** ☐ Yes ☐ No
If yes, please list: ____________________________________ Type of Reaction ________________

**Additional allergies?** Adhesive tape - ☐ Yes ☐ No Iodine/Betadine - ☐ Yes ☐ No Latex - ☐ Yes ☐ No

**Do you smoke?** ☐ Yes ☐ No

**For women only:** Are you currently pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

**Do you wear eyeglasses?** ☐ Yes ☐ No **How old are your current eyeglasses?** ______________
**Do you wear contact lenses?** ☐ Yes ☐ No **Contact lens brand:** __________________ **Last day worn:** _________

**Are you interested in laser vision correction?** ☐ Yes ☐ No
Have you been evaluated for LASIK before? ☐ Yes ☐ No Where: _______________
If yes, what was the recommendation? ☐ LASIK ☐ PRK ☐ I was told that I am not a candidate