VOSS VISION Drs. John & Kendra Voss

(please print)

Date:_____

Name:_____ SS#_____

Address:_____City:_____

State:_____ Zip:_____ Home#:_____

Work#:_____ Cell#:_____ e-mail address _____

Date of Birth:_____ Emergency contact:_____

Work place/school:_____

Occupation/grade:_____ Status: married single divorced

Whom may we thank for referring you to us? _____

How will you be paying today? Cash Check Credit Card Insurance with copays (must have card)

Last eye exam:_____ Doctor: _____

Allergies to medication:_____

List of medications:_____

List all major injuries/surgeries:_____

Who is your primary care physician? _____ When was your last exam? _____

Are you pregnant or nursing? yes no

Do you wear glasses? _____ Do you wear contacts? _____

FAMILY HISTORY

Blindness	yes	no	Relation_____
Cataracts	yes	no	Relation_____
Crossed eye	yes	no	Relation_____
Glaucoma	yes	no	Relation_____
Arthritis	yes	no	Relation_____
Cancer	yes	no	Relation_____
Diabetes	yes	no	Relation_____
Heart disease	yes	no	Relation_____
High blood pressure	yes	no	Relation_____
Kidney disease	yes	no	Relation_____
Lupus	yes	no	Relation_____
Thyroid disease	yes	no	Relation_____
Macular Degeneration	yes	no	Relation_____

SOCIAL HISTORY

Do you use the following?

Tobacco products	yes	no	How long/amount_____
Alcohol	yes	no	How long/amount_____
Illegal drugs	yes	no	How long/amount_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have a chance to receive/view a copy of Voss Vision's Notice of Privacy Practices.

Signature _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

System	NO	YES	?	EXPLAIN / MEDICATIONS
INTEGUMENTARY (Skin)	☐	☐	☐	_____
NEUROLOGIC				
Headaches	☐	☐	☐	_____
Migraines	☐	☐	☐	_____
Seizures	☐	☐	☐	_____
EYES				
Loss of Vision	☐	☐	☐	_____
Blurred Vision	☐	☐	☐	_____
Distorted Vision / Haloes	☐	☐	☐	_____
Loss of Side Vision	☐	☐	☐	_____
Double Vision	☐	☐	☐	_____
Dryness	☐	☐	☐	_____
Mucous Discharge	☐	☐	☐	_____
Redness	☐	☐	☐	_____
Sandy or Gritty Feeling	☐	☐	☐	_____
Itching	☐	☐	☐	_____
Burning	☐	☐	☐	_____
Foreign Body Sensation	☐	☐	☐	_____
Excess Tearing / Watering	☐	☐	☐	_____
Glare / Light Sensitivity	☐	☐	☐	_____
Eye Pain or Soreness	☐	☐	☐	_____
Chronic Infection of Eye or Lid	☐	☐	☐	_____
Sties or Chalazion	☐	☐	☐	_____
Flashes / Floaters in Vision	☐	☐	☐	_____
Tired Eyes	☐	☐	☐	_____
EARS, NOSE, MOUTH, THROAT				
Allergies	☐	☐	☐	_____
Hay Fever	☐	☐	☐	_____
Sinus Congestion	☐	☐	☐	_____
Runny Nose	☐	☐	☐	_____
Post-Nasal Drip	☐	☐	☐	_____
Chronic Cough	☐	☐	☐	_____
Dry Throat / Mouth	☐	☐	☐	_____
RESPIRATORY				
Asthma	☐	☐	☐	_____
Chronic Brochitis	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
VASCULAR				
Diabetes	☐	☐	☐	_____
Heart Pain	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Vascular Disease	☐	☐	☐	_____
GASTROINTESTINAL				
Diarrhea	☐	☐	☐	_____
Constipation	☐	☐	☐	_____
GENITOURINARY (genitals / kidney / bladder)	☐	☐	☐	_____
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis	☐	☐	☐	_____
Muscle Pain	☐	☐	☐	_____
Joint Pain	☐	☐	☐	_____
LYMPHATIC / HEMATOLOGIC				
Anemia	☐	☐	☐	_____
Bleeding Problems	☐	☐	☐	_____
ENDOCRINE (thyroid / other glands)	☐	☐	☐	_____
PSYCHIATRIC	☐	☐	☐	_____

_____ _____

Doctor's Signature Review Date

Another Tool for Preserving Eye Health

If you have never had this test done in this office, the doctor recommends retinal digital imaging to establish a reference point to monitor the changes in your eyes each year. After this initial "baseline" image, the times it will be recommended in the future depends on the condition of the eye. Many of these medical documentation photos can be filed with your medical insurance as part of your medical management and treatment plan.

Retinal Imaging is especially important for people who:

1. Would like a reference image for future comparisons
2. Never had it done before
3. Have a family history of **glaucoma, diabetes, high blood pressure, high cholesterol**
4. Have had a **retinal detachment**, tear, spots or flashes in vision
5. **Sudden change** or loss of vision
6. Reached the age of 40
7. Vision is not correctable to 20/20
8. Have headaches

Screening retinal photography is a NECESSARY part of your eye exam if you fall into any of the above categories. If pathology or a risky condition is documented with these photos, or more are needed, this photographic study can be billed to your insurance as part of your treatment plan. There is an additional charge of $35 for this screening procedure and it is not covered by insurance.

Please check the appropriate line below and sign at the bottom.

_____ I DO want the procedure performed

_____ I DO NOT want the procedure performed

_____ _____

Signature Date