

**Advanced Vision and Achievement Center
Patient Information Form**

Welcome to our office and thank you for choosing Advanced Vision and Achievement Center. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask that you look over this information from time to time to make sure it stays up-to-date.

(Please Print) Circle : Mr-Mrs-Miss-Ms-Dr

Patient Name		Social Security Number/Driver's License Number	
Date of Birth	Gender	Address	City Zip Code
Home Phone		Work Phone	
Cell Phone		Email Address	
Employer/School		Occupation	
Primary Insurance Company (see your insurance card)		Secondary Insurance Company (see your insurance card)	
Name: _____		Name: _____	
Address: _____		Address: _____	
Policy and ID Number: _____		Policy and ID Number: _____	
Name of Insured: _____		Name of Insured: _____	
Date of Birth of Insured: _____		Date of Birth of Insured: _____	
Employer of Insured: _____		Employer of Insured: _____	
Relationship to Patient: _____		Relationship to Patient: _____	
Responsible Party Name		Social Security Number/Driver's License Number	
Date of Birth	Relationship to Patient	Address	
Home Phone		Work Phone	
Cell Phone		Email Address	
Employer/School		Occupation	
Have we seen other family members?		If so, whom?	
How did you find out about our office?			

I acknowledge that I have received the Notice of Privacy Practices from Advanced Vision and Achievement Center.

Date: _____

Signature: _____
(If under 18 years of age, this must be signed by a parent or guardian)

Please list medications: _____

Drug Allergies: _____

PLEASE COMPLETE BACK OF FORM

DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS?

System	No	Yes	Unknown		No	Yes	Unknown
	Please check one				Please check one		
Constitutional				Ear, Nose, Mouth, Throat			
Fever, Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Respiratory			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excessive Tearing or Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/ Hematological			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Self and Family History	No	Yes	Unknown	If Yes, Whom?
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other Eye Problems: _____

Is there a history or reading/learning problems? No Yes If yes, please describe: _____

Social History (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type/amount/how long: _____

Do you drink alcohol? No Yes If yes, type/amount/how long: _____

Do you use illegal drugs? No Yes If yes, type/amount/how long: _____

Have you ever been exposed or infected with: Gonorrhea Hepatitis HIV Syphilis

REVIEW OF SYSTEMS Date/Dr. Sign _____ Date/Dr Sign _____ Date Dr. Sign _____