WELCOME TO **BALITSKI VISION**!

Please take the time to fill out **both** sides of this form so we can provide you with the best eye care possible!

Patient Name _____ Date _____

Address_____City_____
State ___ Zip _____ Email_____
Best phone number to reach you _____ □ Home □ Cell □ Work
Is it OK to text / email you to communicate with you? □ Yes □ No
What is your preferred method of contact? □ Phone □ Email □ Text
Date of Birth _____ Age _____
If a **dependent**: Mother's name _____ Father's name_____
How were you referred to our office? □ Previous Patient □ Phone Book □ Newspaper □ TV □ Ins. Provider List □ Internet □ Other_____
Who can we thank for their kind referral? _____
What is the Primary purpose of your visit? (For example: Eye wellness exam, broken glasses, desire contacts, sudden change in vision, arms too short, etc.)

_____
When was your last eye exam? _____ Last Contact Lens Evaluation? _____

Are you experiencing any of the following problems?

Blurry Vision	□ Yes □ No	Discharge	□ Yes □ No	Burning	□ Yes □ No
Squinting	□ Yes □ No	Itching	□ Yes □ No	Tearing	□ Yes □ No
Double vision	□ Yes □ No	Eye Pain	□ Yes □ No	Light Sensitivity	□ Yes □ No
Flashes of Light	□ Yes □ No	Floating Spots	□ Yes □ No	Other _____	

Do you have any of the following health problems?

High Blood Pressure	□ Yes □ No	Diabetes	□ Yes □ No	Drug Allergies	□ Yes □ No
High Cholesterol	□ Yes □ No	Arthritis	□ Yes □ No	Other Allergies	□ Yes □ No
Thyroid Problems	□ Yes □ No	Lung Disease	□ Yes □ No	Headaches	□ Yes □ No
Circulation Problems	□ Yes □ No	Heart Disease	□ Yes □ No	Past Head Trauma	□ Yes □ No
Sinus Problems	□ Yes □ No	Cancer	□ Yes □ No	Other _____	

Does/did anyone in your blood family have any of the following conditions?

Detached Retina	□ Yes □ No	Blindness	□ Yes □ No	High Blood Pressure	□ Yes □ No
Glaucoma	□ Yes □ No	Diabetes	□ Yes □ No	High Cholesterol	□ Yes □ No
Crossed or Lazy Eye	□ Yes □ No	Cancer	□ Yes □ No	Circulation Problems	□ Yes □ No
Macular Degeneration	□ Yes □ No	Heart Disease	□ Yes □ No	Other _____	

Name of Family Physician _____ Location _____
Medications you are currently taking _____

_____
Drug Allergies □ None Known _____
Type of Vision Insurance: □ None □Davis □Eye Med □Gateway □NVA □Opticare □ Security Blue □UPMC for You □ VSP □ VBA □ Other _____
Major Medical Insurance carrier: □ None □ Other _____

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Have you ever been told you have an eye disease? □ Yes □ No
If yes, which one? _____
Have you ever had any injury or surgery to your eyes? □ Yes □ No
If yes, what type? _____
Do you use drops in your eyes? □ Yes □ No
If yes, what kind and how often? _____
Do you smoke? □ Yes □ No Do you use a computer? □ Yes □ No Hours per Day___
Do you play sports? □ Yes □ No Which ones?_____
Do you have visually demanding hobbies? □ Yes □ No
What are they?_____
Are you getting tired of filling this out? □ Yes □ No Well, you're almost done!

Do you currently wear eyeglasses? □ Yes □ No How old is this pair? _____
How are they worn? □ Distance only □ Near only □ Full-Time □ As Needed
□ When contact lenses are out □ Prescription Sunglasses
What type are they? □Single Vision □Lined Bifocal □No line Multifocal □Don't know
What don't you like about your current eyeglasses?_____
_____
****

Do you wear Contact Lenses? □ Yes □ No □ I used to wear them
If so, which type? Check all that apply:
□ Rigid Gas Permeable/Hard
□ Soft Frequent Replacement (Replaced every one, two or three months)
□ Soft Disposables (Replaced every day, week or two weeks)
□ Special lenses made to correct astigmatism ("Torics")
□ Monovision (One eye for distance, one for near)
□ Multi-focal / Bifocal
What brand of contact lenses do you currently wear?_____ □ I don't know
How many hours a day do you normally wear your contact lenses? _____
How often do you sleep in your lenses? _____ □ I never do
What was the replacement schedule advised by the doctor who fit your lenses?
□ Every day □ Every week □ Every 2 wks □ Every month □ Every 2 months
□ Every three months □ Every year □ I don't have the foggiest idea
How often do you replace your lenses (HONESTLY)? Every_____ □ I don't know
How old is the pair you are wearing now? _____ □ I don't know
What solutions do you use? _____□ I don't know
Are you currently having any problems with your lenses? □ No □ Dryness □ Burning
□ Itching □ Poor Vision □ Poor Comfort □ Poor handling □ Other _____
Do you feel that eye health is important when you wear contact lenses? □ Yes □ No

Thank you for taking the time to complete this questionnaire!