Moscow Vision Clinic

Randall Cummings, O.D., Behavioral Optometrist

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General Information:

Full Name: ____________________________________

Address: ____________________________________

City: _________________ State: ______ Zip: _________

Home Phone: ________________________________

Work Phone: ________________________________

Cell Phone: ________________________________

Birth Date: ______________________ Age: _________

Occupation: ________________________________

Do you currently attend school? Yes___ No___

Where: ____________________________________

Who referred you and why? ____________________

Health History:

List any major illness or injury: Age Mild Severe

________________________ _____ _____ _____

________________________ _____ _____ _____

________________________ _____ _____ _____

________________________ _____ _____ _____

Visual History:

Do you wear contact lenses? Yes___ No___

Have you worn contacts in past years? Yes___ No___

Is a visual problem keeping you from doing anything?

Yes___ No___ If yes, what? ______________________

Previous visual examination:

Reason for Exam _______________ Doctor ____________

Date __________ Results ___________________________

Present Situation:

What is the main visual difficulty you are having? ____

____

How long has this been going on? ____

List any current medications: ____

List any allergies: ____

Instructions: For each question check the box that most closely corresponds to your answer.

1 = always 2 = often 3 = sometimes 4 = rarely 5 = never

	1	2	3	4	5		1	2	3	4	5
1. Do you suffer from blurred vision?						8.Do you get tired when reading?					
2. Do you loose your concentration while reading?						9. When looking up from reading do objects appear momentarily blurred?					
3. Does your vision seem worse at the end of the day than in mornings?						10. Does prolonged reading or close work give you headaches?					
4. Do you experience Double Vision?						11. After reading for awhile, does the print begin to appear blurry?					
5. Do you often close an eye when reading?						12. Do you ever have car sickness?					
6. Do your eyes feel tired at the end of the day?						13. Is reading in a moving vehicle difficult?					
7. Do words seem to run together when reading?						14. When reading do you ever find that you skip or repeat lines?					

How many hours a day do you: _____use a computer _____read _____watch tv _____play video games

Are you involved in sports? Yes_____ No_____ Which One(s) ___________________________________

What kind of exercise do you do? ____

Do you or any family members have the following conditions, now or in the past?

Systemic Disease/Condition

	Yes	No	Self or Relationship
Arthritis	☐	☐	____________
Diabetes	☐	☐	____________
Rheumatoid Arthritis	☐	☐	____________
Allergies	☐	☐	____________
Weight (loss/gain)	☐	☐	____________
Cancer	☐	☐	____________
Drug Sensitivity	☐	☐	____________
Elevated Cholesterol	☐	☐	____________
Heart Problem/Disease	☐	☐	____________
High Blood Pressure	☐	☐	____________
Thyroid	☐	☐	____________
Migraine or Headaches	☐	☐	____________
Skin (acne, cancer)	☐	☐	____________
Gastrointestinal	☐	☐	____________
Kidney, bladder	☐	☐	____________
Neurological (MS, seizures)	☐	☐	____________
Psychiatric (depression/etc.)	☐	☐	____________
Respiratory (asthma/etc.)	☐	☐	____________
Lupus	☐	☐	____________
Other ________________	☐	☐	____________
	☐	☐	____________
	☐	☐	____________

Ocular Disease/Condition

	Yes	No	Self or Relationship
Lazy Eye	☐	☐	____________
Turned Eye	☐	☐	____________
Crossed Eyes	☐	☐	____________
Color Blind	☐	☐	____________
Light Sensitive	☐	☐	____________
Eyestrain	☐	☐	____________
Dry Eyes	☐	☐	____________
Floaters/Spots	☐	☐	____________
Flashing Lights	☐	☐	____________
Retinal Detachment (disease)	☐	☐	____________
Blindness	☐	☐	____________
Macular degeneration	☐	☐	____________
Cataracts	☐	☐	____________
Glaucoma	☐	☐	____________
Head Trauma	☐	☐	____________
Eye Surgery ____________	☐	☐	____________

Date of your last physical:________________________

How was your general health? (circle one)

Excellent Good Fair Poor

Are you currently under a physician's care?

Yes___ No___ Name of doctor:_________________

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorized payment of these benefits directly to **Randall Cummings, O.D.** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

In order to keep cost down, payment may be expected in full at time of service. We would be more than happy to help you submit your insurance forms in order for you to be reimbursed.

I have read, understood, and agree to billing terms and conditions:

Signature: ____ **Date:**___________________________

Financially Responsible Party:

Name____ Relationship___________________________

Phone Number:______________________________

Address: ____

City____________________________ State_____ Zip ____________