



Vision Source!®

Vince McGlone, O.D. Heather Deeble, O.D.

| Date: | Who may we thank for referring |
|---|--|
| | you? |
| Name: Miss Ms. Mrs. Mr. Dr. | Address: |
| | Tel. # |
| SS# | |
| Address: | Primary Care Physician name and address: |
| Tel.# (H): | PCP |
| 1ei# (w):ext | phone: |
| E-mail: | PCP |
| | fax: |
| Occupation: | Date of last visual exam |
| Employer: | Date of last physical exam |
| Address: | Insurance: |
| | |
| DOB: | Teacher: |
| SS# | School Nurse: |
| | Hobbies: |
| Please check the following: | |
| Are you a contact lens wearer?Yes No Hard () Soft () Gas Permeable () Semi-soft () Extended Wear () | Have you ever had: |
| raid () Soit () Gas Permeaule () Semi-soit () Extended wear () | Head injuryYes No When |
| How longLast worn Fit by Dr | Eye or lid surgery Yes No When Yes No When |
| List all solutions and brands presently used | Visual Training Yes No When Yes No When Yes No When |
| Elst un solutions and orange presently used | Lye infection1 es No when |
| Check all that apply: | |
| () Smoke () Diabetes | Check for problems you have noticed: |
| () Oral contraceptives () Blood Pressure problems | () Headaches () Blurry at Near () Eyes Tired () Blurry at Far |
| () Sinus problems () Glaucoma | () Red Eyes () Eyes Watering |
| () Heart problems | () Eye Aches () Double Vision |
| Is there a family history of: | () Twitching () Light Flashes |
| () Glaucoma () Diabetes | () Light Sensitivity () Floating Spots |
| () Blood Pressure Problems () Blindness | () Poor Night Vision |
| | Liet Allaurias |
| And the second description of the second | List Allergies |
| Are there any other pertinent health issues? | |
| Please explain | List Medications, Treatments and Diagnosis (current): |
| | |
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