The Vision Studio, OD, PLLC
Dr. Amy Lin Kasper & Dr. Ira S. Tucker
Patient History

Patient Name: Dr./Mr./Mrs./Ms/ Miss	**Address/City/State/Zip**
Date of birth:	SSN:
Telephone:	Email:
Occupation:	Employer:
NEW PATIENTS — Date of last eye exam:	Last eye doctor and location :
How did you hear about our practice?	Do any family members come to this practice?
If **YES** please list name and relationship:	Emergency contact name and telephone number:
Primary Care Physician:	Name of practice:
VISION INSURANCE - Please list insurance	**Subscriber name and ID number**
MEDICAL INSURANCE - Please list insurance	**Subscriber name and ID number**

PLEASE NOTE: Patients are responsible for payment of overages, co-payments or amounts not covered by insurance.

MEDICAL INFORMATION

Do you have any problems with any of these systems? Please check all that apply.

☐ Gastrointestinal	☐ Ears/Nose/Throat	☐ High BP	☐ Respiratory
☐ Nervous	☐ Genitourinary	☐ Musculoskeletal	☐ Skin

☐ Eyes	☐ Mental	☐ Diabetes	☐ Blood/Lymp
☐ Allergic/ Immunologic	☐ High Cholesterol	Please explain:	
Medication allergies :	**YES** or **NO**	Allergic to:	
Other allergies:	**YES** or **NO**	Allergic to:	
Headaches:	**YES** or **NO**	Other health problems:	
Current medications:			
Have you had any operations?	**YES** or **NO**	Type & date:	
Do you use cigarettes, tobacco?	**YES** or **NO**	Alcohol?	**YES** or **NO**
Other substances?	**YES** or **NO**		

FAMILY HISTORY

Macular degeneration?	**YES** or **NO**	Relationship:	
Retinal detachment?	**YES** or **NO**	Relationship:	
Glaucoma?	**YES** or **NO**	Relationship:	
Other eye conditions?	**YES** or **NO**	What kind? Relationship:	

PERSONAL EYE HEALTH INFORMATION

Have you had any eye operations?	**YES** or **NO**	Type & Date?	
Have you had any eye injuries?	**YES** or **NO**	Type & Date?	
Do you have glaucoma?	**YES** or **NO**		
Blurred vision?	**YES** or **NO**		
Dry eyes?	**YES** or **NO**		
Other eye problems?	**YES** or **NO**	Please explain:	
Do you wear glasses?	**YES** or **NO**	Contact lenses	**YES** or **NO**
What type of contacts do you wear?		Are you interested in wearing contacts?	**YES** or **NO**

Patient initials _____ Date:_____
Doctor initials _____ Date:_____