

Beckley Vision Center, PLLC

1928 Harper Road • Beckley, WV 25801
(304) 252-1299 • 1-800-834-3627

David R. Holliday, O.D.
Mark E. Holliday, O.D.



Good vision begins with us

Name _____

Sex: M ___ F ___ Birth Date ____/____/____

Street _____

Social Security Number _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Employer (or School) _____

Spouse (or parent's name) _____

Occupation (or Grade) _____

Spouse (or parent's place of employment) _____

Spouse (or parent's work phone) _____

Do you . . .

- . . . Work at a computer for long periods? Yes No
- . . . Have more than one pair of glasses? Yes No
- . . . Want information on thinner, lighter lenses? Yes No
- . . . Wear bifocals? Yes No
- . . . (If yes, are you bothered by head tilting, restricted areas of vision correction, etc.) Yes No
- . . . Have times you would rather not wear your glasses? Yes No
- . . . Spend time outdoors? (how much?) _____ hrs/week

- . . . Have prescription sunglasses? Yes No
- . . . Have problems with glare or reflection, particularly when driving at night? Yes No
- . . . Have family members in need of eyecare? Yes No

Have you ever worn / are you currently wearing contacts?

Yes No

What kind?: _____ Solutions used _____

Are you interested in contact lenses? Yes No

Medical History

Name of Medical Doctor: _____ Dr.'s Phone: _____ Last Medical Exam: ____/____/____

Do you have any allergies to medications? Yes No If yes, list which medications: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List any major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, dropping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? Yes No

I WILL BE RESPONSIBLE FOR CHARGES INCURRED WITH THIS OFFICE IN THE EVENT THAT MY INSURANCE DENIES PAYMENT (INCLUDING MEDICARE BENEFITS). I AGREE TO BE FULLY RESPONSIBLE TO DRS. HOLLIDAY. (In the event patient's account is turned over to collection, patient will be responsible for usual and customary collection charge.)

Signature (Patient, Parent or Guardian): _____ Date: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	?	DISEASE/CONDITION	YES	NO	?
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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

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

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

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

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

REVIEW OF SYSTEMS

Do you currently have, or have you ever had, any problems in the following areas:

SYSTEM	YES	NO	?	SYSTEM	YES	NO	?
CONSTITUTIONAL				EARS, 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"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<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/Halos	<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			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/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			
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 or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties 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/HEMATOLOGIC			
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"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Reviewed by: _____

Doctor's Signature

Date