North Valley Eye Care, P.C. • Dr. Justin L. Kohls • Dr. Michelle A. Kohls

Name:____ **Date of birth:** ____/____/______

Cell phone: (____)_______________ **Telephone:** (____)_________________ **Email :** ______________________________

Communication preference? ☐ **Text Message** ☐ **Telephone** ☐ **Email**

Have there been any changes in your overall health since your last visit? ☐ No ☐ Yes, please explain:________________
____

Height: _______ **Weight:**_______ **Last Blood Pressure Reading:** _______/_______

Preferred language? ☐ English ☐ Spanish

Race? ☐ White ☐ Hispanic ☐ Black or African American ☐ Asian ☐ American Indian ☐ Native Hawaiian

Ethnicity? ☐ Hispanic or Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Not Hispanic or Latino

Social History for Adults

Alcohol Use? ☐ None ☐ Social Use Only ☐ 1-2 drinks daily ☐ Above average use ☐ Alcohol Dependence

Tobacco Use? ☐ Never Smoked ☐ Former Smoker ☐ Light Smoker (1-9 cigs/day) ☐ Every day Smoker

☐ Heavy Tobacco smoker ☐ Smokeless tobacco user

Narcotic Use? ☐ None ☐ Recreational Use ☐ Chemical Dependence

For Contact Lens Wearers…

Annual Contact Lens Evaluation and Fitting:

Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. Contact lenses are medical devices and even though they may feel fine, there are health risks that must be taken seriously. In order to renew your contact lens prescription, your doctor performs the following tests on a yearly basis. These procedures are not part of a standard eye exam.

- Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
- Slit lamp microscope examination of the cornea, conjunctiva and eyelid tissues, to check the eye health and to look for adverse effects from contact lens wear.
- Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions).
- We also review new lens designs, materials and cleaning solutions that may improve comfort and/or health.

Your vision insurance may claim to pay for your contact lens fitting, but in this case they always subtract the fitting amount from your contact lens material allowance. When you pay for the contact lens fitting today, you will have your entire contact lens allowance for the purchase of contact lenses (or for glasses lenses if you decide at any time not to purchase contact lenses).
If you have never worn contact lenses, there is an additional training fee of $35.
Contact lens fittings start at $71.

Signature____Date______/______/_____

Vision Complaints: **Please check any vision complaints or** ☐ None

☐ Blurred Vision at Distance ☐ w/ Glasses ☐ w/ Contacts or ☐ w/out correction
☐ Blurred Vision at Near ☐ w/ Glasses ☐ w/ Contacts or ☐ w/out correction
☐ Blurred Vision at Computer ☐ w/ Glasses ☐ w/ Contacts or ☐ w/out correction

For School-Aged Patients

Are there any challenges with reading or learning? Please explain. ______________________________________
____

Ocular Health Symptoms:

Please check ocular health symptoms or ☐ **None**

Which eye is affected?

☐ Right Eye
☐ Left Eye
☐ Both Eyes affected

Ocular Symptoms you currently have?

☐ Pain
☐ Pressure feeling
☐ Foreign body sensation
☐ Dry/sandy feeling
☐ Some redness
☐ Extreme redness
☐ Burning
☐ Itching
☐ Eyelid Swollen
☐ Eyelid droopy
☐ Eyelid crusty
☐ Watery eye
☐ Lids stuck together upon awakening
☐ Increased light sensitivity ☐ Mucous-like discharge
☐ Eyelid twitching
Other symptoms:__________________________________

Onset of Ocular Health Symptoms?

☐ Today
☐ Yesterday
☐ Mornings
☐ Evenings
☐ As the day wears on
☐ Recently (in last 7 days)
☐ Increased over time

Duration Ocular Health Symptoms?

☐ One time only
☐ Comes and goes
☐ Persistent
☐ Seasonal

Severity Ocular Health Symptoms?

☐ Mild
☐ Bothersome
☐ Very bothersome
☐ Lessening
☐ Remaining the same
☐ Increasing

Context Ocular Health Symptoms?

☐ No known cause
☐ Worse in right eye
☐ Worse in left eye
☐ Both eyes affected
☐ Post-trauma relationship
If yes, Please Explain:_________________________________

Eye Medications (Please list all used recently, including over-the-counter) ____
____

Have you seen another provider for this eye health condition? ☐ No ☐ Yes **If yes, please explain.**
____
____
____

What pharmacy do you prefer? Please list the cross streets. ____

For All Patients…

Acknowledgement of HIPAA Policies:

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature____ Date______/______/______

Acknowledgement of Financial Policies:

I hereby authorize North Valley Eye Care, P.C. to release information that is required by my insurance carrier.
I acknowledge that I am financially responsible for all non-covered charges including annual contact lens fitting fees.

Signature____Date______/______/____