GALLOWAY
Eye Care Professionals, Inc
5688-A West Broad Street
Galloway, OH 43119
Phone: 614-853-2020 Fax: 614-853-0154
Jennifer A. Mattson, O.D., Richard J. Vesler, O.D., Rheanna Moore, O.D.

Name: _____ Date: _____/_____/_____
Age: _____Date of Birth:____/____/_____Gender: M / F Salutation: Mr. Miss Ms. Mrs. Dr. Prof.
Address: _____City: _____State: ____ Zip Code: _____
Home Phone: (_____)_____-_____Cell Phone:(____)_____-_____Work Phone:( )____-_____
Social security number: _____ Email address: _____
Guardian (if patient is under 18): _____

Vision insurance carrier: VSP EyeMed Medicaid/Caresource/Molina Other: _____
Medical insurance carrier: Anthem Aetna Cigna Medical Mutual Medicare
Tricare Meritain Humana United HealthCare Other: _____
Primary insured name: _____ DOB: _____
Secondary insurance name:_____ Ins ID#_____ DOB: _____
**Please have your insurance cards ready for our staff to copy, thank you. Co-pays are due at the time of service.

Reason for Examination (circle all that apply): blurred vision at distance / near / computer

eyes watery/itchy eyes dry headaches eyestrain eye pain redness flashes/floaters

annual exam for diabetes annual exam for hypertension need new contact lenses / glasses

referred by another doctor vision therapy assessment reading problems double vision

Ocular History:
Last Eye Exam (month/year):_____Doctor's name: _____
Do you wear… glasses contact lenses both Are you interested in contact lenses? Y / N
Age of current glasses _____ Do you work on a computer? Y / N #hours/day: _____
Current contact lens wearers only:
Type/brand of current lenses: _____ Replacement schedule: _____
Average wearing time daily: _____ Solution used: _____
Do you sleep in your lenses? Y / N How many days per week do you wear your lenses? _____
If you could change something about your lenses it would be: _____

***Contact lens services are not covered under a regular eye exam.** In order to obtain a prescription for contact lenses, an additional evaluation (contact lens fitting) must be done. The price for this service varies based on your prescription and the complexity of the fit. Your fitting fee will cover any necessary follow up visits and any diagnostic lenses used to determine your contact lens prescription. Our doctors are committed to your success in contact lenses. If you have questions regarding this fee, please talk to a staff member.

Personal Ocular History (have you ever been diagnosed with or suffer from the following)**:**

Glaucoma	Y / N
Cataracts	Y / N
Macular Degeneration	Y / N
Injury	Y / N
Retinal Disease	Y / N
Blindness	Y / N
Strabismus (Eye turn)	Y / N
Amblyopia (Lazy Eye)	Y / N
Dryness	Y / N
Flashes	Y / N
Floaters	Y / N
Vision Loss	Y / N

Other (please describe):
_____

Family Ocular History (has a blood relative been diagnosed with the following):

Glaucoma Y / N Relationship: _____
Cataracts Y / N Relationship: _____
Macular Degeneration Y / N Relationship: _____
Retinal Disease Y / N Relationship: _____
Blindness Y / N Relationship: _____
Strabismus (eye turn) Y / N Relationship: _____
Amblyopia (lazy eye) Y / N Relationship: _____
Other (please describe) Y / N
Relationship:
_____

Medical History:

Family Physician:_____ Last Physical Exam (month/year):_____

Personal medical history (have you ever had or taken medication for the following):

General Health:
Recent trauma Y / N
Weight loss/gain Y / N
High fever Y / N
Other: _____
Cardiovascular:
High blood pressure Y / N
Heart disease Y / N
High Cholesterol Y / N
Stroke Y / N
Heart attack Y / N
Other: _____
Ears, nose, mouth, throat:
Chronic sinusitis Y / N
Chronic strep Y / N
Hearing loss Y / N
Other: _____
Respiratory:
Asthma Y / N
COPD Y / N
Emphysema Y / N
Sarcoid Y / N
Chronic Bronchitis Y / N
Other: _____

Gastrointestinal (GI):
Reflux Y / N
Ulcer Y / N
Gall Bladder Y / N
Hernia Y / N
IBS Y / N
Other: _____
Musculoskeletal:
Arthritis Y / N
Muscle pain Y / N
Fibromyalgia Y / N
Chronic back pain Y / N
Other: _____
Integumentary (skin):
Rosecea Y / N
Skin Cancer Y / N
Eczema Y / N
Psoriasis Y / N
Other: _____
Neurological:
Seizures Y / N
Epilepsy Y / N
Multiple Sclerosis Y / N
Migraine Y / N
Other: _____

Psychiatric:
Depression Y / N
Anxiety Y / N
AD/HD Y / N
Other: _____
Endocrine:
Diabetes Y / N
Thyroid Y / N
Pituitary disorders Y / N
Other: _____
Blood/ Lymphatic:
Anemia Y / N
Sickle Cell Y / N
Leukemia Y / N
Other: _____
Genitourinary:
Recurrent bladder inf Y / N
Kidney stones Y / N
STD Y / N
Other: _____
Allergic/Immunologic:
Seasonal allergies Y / N
Lupus Y / N
HIV/ AIDS Y / N
Other: _____

Medications:_____
_____
Do you have any known drug allergies: Y / N List: _____

Family Medical History (has a blood relative been diagnosed with the following):

High blood pressure Y / N Relation: _____
Heart attack Y / N Relation: _____
Stroke Y / N Relation: _____
Cancer Y / N Relation: _____
Diabetes Y / N Relation: _____
Thyroid problems Y / N Relation: _____
Multiple Sclerosis Y / N Relation: _____
Lupus Y / N Relation: _____

Social history:

Occupation: _____ Hobbies: _____
Special visual needs: _____

Do you drink alcohol? Y / N Average drinks per week: _____
Do you use tobacco? ` Y / N Cigarettes # packs per day: _____ Pipe Cigar Smokeless tobacco
Do you use recreational drugs? Y / N List: _____

Please list any surgeries you have had in your lifetime: _____
Other pertinent health history: _____

**Thank you, your information is protected under HIPAA and is confidential.