RISING STAR OPTOMETRY &
VISION ACADEMY OPTOMETRY

GENERAL INFORMATION

Please fill in the applicable information

Name_______________________________________ Date____________

Date of Birth ______________________ Age_____________

Address____

Home Phone: (______)__________________
Cell Phone: (______)__________________
Work Phone: (______) __________________
Fax: (______)__________________

Occupation: ____

Email Address: _______________________________________

Emergency Contact: ___________________________________

Phone: (______)___________________

Physician ____

Phone (______) ___________________

Address____

Who referred you?____________________________________

Phone (______)___________________

Address____

Medical History   Vision Academy Optometry & Rising Star Optometry

Name: ____________________ Date of Birth: ______________ Gender: __________
Address: ______________________ Phone: ______________________
____

Name of Medical Doctor: __________________ Dr.'s Phone #: __________________
Name of Previous Eye Doctor: ______________ Dr.'s Phone #: __________________

Reason(s) for Visit: ______________________________________

List any allergies to medicines, foods, or seasonal (do they affect your eyes?):

____

____

List any medications you take (including oral contraceptives, aspirin, OTC meds, vitamins/herbals, etc):

____

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________

____

Are you pregnant or nursing? ❑ Yes ❑ No

Do you wear glasses? ❑ Yes ❑ No If yes, how old are your lenses? ______________________

Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your current pair? ______________________

What type of contact lenses: ❑ Disposable Soft Lenses ❑ Standard Soft Lenses ❑ Rigid

If you use disposable lenses how often do you throw them away? ______________________

What solutions do you use? ______________Do you ever sleep in your lenses? ❑ Yes ❑ No

Personal/Family History
Please answer the questions below regarding you or your immediate family (parents, grandparents, siblings, children) for the following:

	You		Family			How are they related to you?
	Yes	No	Yes	No	?	
Blindness/Loss of Vision	❑	❑	❑	❑	❑	______
Crossed Eyes	❑	❑	❑	❑	❑	______
Glaucoma	❑	❑	❑	❑	❑	______
Macular Degeneration	❑	❑	❑	❑	❑	______
Retinal Detachment	❑	❑	❑	❑	❑	______
Retinal Disease	❑	❑	❑	❑	❑	______
Cancer	❑	❑	❑	❑	❑	______
Diabetes	❑	❑	❑	❑	❑	______
Heart Disease	❑	❑	❑	❑	❑	______
High Blood Pressure	❑	❑	❑	❑	❑	______
Lupus	❑	❑	❑	❑	❑	______
Thyroid Disease	❑	❑	❑	❑	❑	______
Other ______	❑	❑	❑	❑	❑	______

Social History:

Do you drive? ❑ Yes ❑ No If yes, do you have difficulty with vision while driving? ❑ Yes ❑ No

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 illicit drugs? ❑ Yes ❑ No If yes, type/amount/how long: ______________________

Review of Systems

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

	Yes	No	?		Yes	No	?
Constitutional				***Ears/Nose, Mouth, Throat***			
Fever/Weight Changes	❑	❑	❑	Allergies/Hay Fever	❑	❑	❑
Integumentary (Skin)	❑	❑	❑	Sinus Congestion	❑	❑	❑
Rosacea	❑	❑	❑	Dry Throat/Mouth	❑	❑	❑
Neurological				***Respiratory***			
Headaches	❑	❑	❑	Asthma	❑	❑	❑
Migraines	❑	❑	❑	Emphysema	❑	❑	❑
Seizures	❑	❑	❑	Chronic Bronchitis	❑	❑	❑
Eyes				***Vascular/Cardiovascular***			
Blurred Vision	❑	❑	❑	Diabetes	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑	Vascular Disease	❑	❑	❑
Loss of Side Vision	❑	❑	❑	High Cholesterol	❑	❑	❑
Double Vision	❑	❑	❑	High Blood Pressure	❑	❑	❑
Dryness	❑	❑	❑	***Gastrointestinal***			
Mucous Discharge	❑	❑	❑	Chronic Diarrhea	❑	❑	❑
Redness	❑	❑	❑	***Genitourinary***			
Sandy or Gritty Feeling	❑	❑	❑	Kidney/Bladder	❑	❑	❑
Itching	❑	❑	❑	***Bones/Joints/Muscles***			
Burning	❑	❑	❑	Rheumatoid Arthritis	❑	❑	❑
Foreign Body Sensation	❑	❑	❑	***Lymphatic/Hematologic***			
Glare/Light Sensitivity	❑	❑	❑	Anemia	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑	Bleeding Problems	❑	❑	❑
Styes	❑	❑	❑	***Endocrine***			
Flashes/Floaters in Vision	❑	❑	❑	Thyroid	❑	❑	❑
Tired Eyes	❑	❑	❑	***Psychiatric***	❑	❑	❑
				Other	❑	❑	❑

Are you interested in **soft contact lenses**? ❑ Yes ❑ No, **Bifocal/Multifocal** contact lenses? ❑ Yes ❑ No

Are you interested in **Orthokeratology** (near-sighted vision correction that allows clear vision throughout the day without glasses or daily contacts)? ❑ Yes ❑ No

Have you ever had **refractive surgery**? ❑ Yes ❑ N, If yes, specify type: ❑ LASIK ❑ PRK ❑ RK ❑ LASEK

Are you interested in laser surgery? ❑ Yes ❑ No

Patient Signature: ______________________ Date: __________

Physician Signature: ______________________ Date: __________

Consent for Treatment, Rising Star Optometry/Vision Academy Optometry

PATIENT'S NAME: ______________________________________

I voluntarily give my permission to the healthcare providers of Rising Star Optometry ("RSO") and Vision Academy Optometry ("VAO") and such assistants and other health care providers, as they may deem necessary to provide medical services to me/my child. I understand by signing this form, I am authorizing them to treat me/treat my child as long as I seek care from RSO and VAO.

Patient/Parent/Guardian Initials: ________

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the care and treatment provided my representatives of RSO and VAO. I understand that RSO and VAO are not contracted with insurance carriers and that **payment is due in full at the time of visit**. RSO and VAO will make every effort to provide you with an insurance superbill that may be submitted to your insurance carrier for reimbursement. I understand that this does not guarantee I will be reimbursed for these medical services provided by RSO and VAO.

Patient/Parent/Guardian Initials: ________

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received the Notice of Privacy Practices from RSO and VAO. I also understand that information contained in this form and collected during my examination may be used for teaching purposes or statistical analysis.

Patient/Parent/Guardian Initials: ________

Consent to Communicate Via Email- Email is not HIPAA Compliant

I voluntarily give my permission to RSO and VAO to Communicate with me or my child via Email. This communication could include but is not limited to: appointment reminders, spectacle/contact lens prescriptions and notifications (by request), and exam reports, letters, or evaluations. I give this permission understanding that e-mail may be unencrypted and therefore is not secure. E-mail contents and attachments may be read by unintended recipients.

Circle one:

YES I give permission to communicate using this address:

____

NO I do NOT want any communication to occur via e-mail.

Patient/Parent/Guardian Signature :

____ Date ____________

Print Name: ________________________________ Relationship ____________________

RISING STAR OPTOMETRY &
VISION ACADEMY OPTOMETRY

Visual Skills Symptom Survey

Dr. David Grisham, OD, MS, FAAO, FCOVD-A, Dr. Jeremy Shumaker, OD
Ph: (415) 459-2020, Email: risingstaroptometry.com

Instructions: read the *Subject Instructions* and then each item exactly as written. Name:_______________________________ Age:__________
If subject responds with "yes" – please qualify with frequency choices. Do not give examples. Today's Date:___________
Subject Instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

		Never (0)	Infrequently (1)	Sometimes (2)	Fairly Often (3)	Always (4)
1	Do your eyes feel tired when reading or doing close work?					
2	Do your eyes feel uncomfortable when reading or doing close work?					
3	Do you have headaches when reading or doing close work?					
4	Do you feel sleepy when reading or doing close work?					
5	Do you lose concentration when reading or doing close work?					
6	Do you have trouble remembering what you have read?					
7	Do you have double vision when reading or doing close work?					
8	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9	Do you feel like you read slowly?					
10	Do your eyes ever hurt when reading or doing close work?					
11	Do your eyes ever feel sore when reading or doing close work?					
12	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14	Do you lose your place when reading or doing close work?					
15	Do you have to re-read the same line of words when reading?					

Add up total number of points. Consider referral for a Visual Efficiency Exam if total score is 16 or higher for kids, 22 for adults.

TOTAL SCORE: ______

Adapted From: Convergence Insufficiency Symptom Survey---V15 from Borsting EJ, Rouse MW, Mitchell GL, Cotter SA et al. (2003) Validity and reliability of the revised convergence insufficiency symptom survey in children aged 9 to 18 years. Optom Vis Sci 80:832=-838.