Family Vision Health Center

modern eye care • old-fashioned caring

David Carotenuto, O.D.

Pediatric and Adult Optometry

411 State Highway 34, The Courtyard

Colts Neck, New Jersey 07722

(732) 409-0100 www.FamilyVisionHC.com

WELCOME BACK TO OUR OFFICE

(**PLEASE PRINT)**

Name_____

Street_____

City_____ St._____ Zip_____

Home Phone_____ Work Phone_____

Cell_____

May we contact you by text? ☐ Yes ☐ No

Email address_____

May we contact you by email? ☐ Yes ☐ No

Employer (or school) _____

Occupation (or grade) _____

Today's Date _____

Date of Last Full Eye Exam_____

Vision Insurance_____

Medical Insurance_____

(Insurance requires that you show your card each visit)

Do you have an FSA (Flex Spending Plan)? ☐ Yes ☐ No

Contact Lenses Worn ☐ Yes ☐ No

Interested in trying ☐ Yes ☐ No

Replacement frequency

____Daily ____Weekly ____Bi-Weekly

____Monthly ____Quarterly ____Yearly

Solution used_____

Did you know that you can now **make** or **reschedule appointments** and **order contacts online** at::

www.FamilyVisionHC.com

Current Medications (Rx or Over the Counter)

	Name of Medication
Antihistamines	No__ Yes_____
Diuretics (Water Pills)	No__ Yes_____
Blood Pressure Pills	No__ Yes_____
Oral Contraceptives	No__ Yes_____
Diabetic Meds	No__ Yes_____
Eye Drops	No__ Yes_____
Other _____	No Yes_____

☐ I do not use any medications or eye drops.

Name of Family Physician or Pediatrician?

_____

Medical History

Allergies	No___	Yes___	Family_____
Asthma	No___	Yes___	Family_____
Skin Disorder	No___	Yes___	Family_____
Eye Disease	No___	Yes___	Family_____
Eye Injury	No___	Yes___	Family_____
Eye Surgery	No___	Yes___	Family_____
Lazy Eye	No___	Yes___	Family_____
Cataracts	No___	Yes___	Family_____
Glaucoma	No___	Yes___	Family_____
Arthritis	No___	Yes___	Family_____
Cancer	No___	Yes___	Family_____
Diabetes	No___	Yes___	Family_____
Heart Disease	No___	Yes___	Family_____
High Blood Pres	No___	Yes___	Family_____
Other	No___	Yes___	Family_____

Do You Experience…

☐ Burning ☐ Itchiness ☐ Tearing ☐ Redness

☐ Dryness ☐ Eye Pain ☐ Spots ☐ Flashes

☐ Nausea ☐ Headaches ☐ Double Vision

☐ Dizziness ☐ Grittiness ☐ Sensitivity to Light

☐ Eye Strain ☐ Blurry Distance Vision

☐ Reading Problems ☐ Trouble working up-close

☐ Glare or reflection ☐ Uncomfortable contact lenses

☐ Other _____

☐ I understand that if my insurance does not cover Vision Care Services, I (or parent) will be responsible for payment or balances.

Signature_____