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 TO OUR OFFICE

(**PLEASE PRINT**)

Name_____
Street_____
City_____ St.____ Zip_____
Home Phone_____ Work Phone_____
Cell_____
Email address_____
May we contact you by email? ____Yes ____No
Employer (or school) _____
Occupation (or grade) _____
Today's Date_____ Date of Birth_____
Date of Last Full Eye Exam_____ Sex: ☐ M ☐ F
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work Phone _____
Vision Insurance_____
Medical Insurance_____
How did you hear about our office? _____
Do you have an FSA (Flex Spending Plan)? ☐ Yes ☐ No

Prescription Glasses Worn ☐ Yes ☐ No
☐ Distance ☐ Reading ☐ Computer ☐ Sunglasses
Type of Glasses
☐ Single Vision ☐ Progressive ☐ Bi or Tri Focal

Contact Lenses Worn ☐ Yes ☐ No ☐ Interested in trying

		Right	Left
Replacement	Brand		
☐ Daily	Power		
☐ Weekly	Base		
☐ Bi-Weekly	Diameter		
☐ Monthly	Solution used		
☐ Quarterly	How much do you wear them?		
☐ Yearly			

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.

☐ I authorize the release of medical information concerning me to evaluate and pay medical claims.
Signature_____

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