Welcome to Our Office!
Dr. Jaime Blyskal Marcolini, Dr. William R. Marcolini, Dr. John Hnatyko

Patient Name_____
Street_____
City_____State_____ Zip_____
Home Phone_____
Work Phone_____
Cell Phone_____
Patient's SSN_____
Occupation (or Grade)_____
Date of Birth_____/_____/_____ Age_____ Sex M F
E-mail Address_____
What is the purpose of today's visit?
_____
Are there any problems with your current contact lenses or glasses?_____
VERY IMPORTANT! New Patients Only!
Who may we thank for referring you to our office?
Name of friend or relative_____
If not referred how did you choose our office for your needs?_____

INSURANCE INFORMATION

Vision Insurance_____
Subscriber Name_____
Sunscriber SSN_____
Do you have coverage for glasses or contacts? Y N
Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Do you participate in a flex spending account? Y N

I understand that it is not the responsibility of this office to know my insurance coverage. I am ultimately responsible for the payment of my medical bill in the event I have not met my deductible for the year, do not have routine vision coverage or I exceed the allowances of my insurance coverage. I understand that all co-pays, deductibles, contact lens service fees and Optomap photos, not covered by most insurance, are to be paid in full today.

_____ Date___/___/___
Signature

FAMILY MEDICAL/EYE HISTORY

Is there a family history of any of the following?

	Relationship
___ Blindness	_____
___ Cataracts	_____
___ Corneal Problems	_____
___ Glaucoma	_____
___ Lazy Eye	_____
___ Macular Degeneration	_____
___ Retinal Problems	_____
___ Diabetes	_____
___ Heart Disease	_____
___Other	_____

PATIENT MEDICAL/ EYE HISTORY

Name of Family Physician_____
Date of last physical exam_____
Date of last eye exam_____

Optometric Physician's Signature _____
Date____/____/____ Reviewed on___/___/___
Reviewed on___/___/___

Current Medications (prescription or over the counter)

_____
_____
_____

Allergies to Medications: Y N
Please list_____

	Yes	NO
Eyes (Glaucoma, cataract, retinal disease, uveitis, eye infection, eye injury)		
Blurred Vision/loss of vision/fluctuating vision		
Distorted Vision (haloes)/ double vision		
Dryness/sandy or gritty feeling		
Mucous discharge		
Redness/itching/burning/tearing		
Glare/light sensitivity		
Eye pain or soreness/ tired eyes		
Infection of lid (blepharitis)/drooping eyelid		
Crossed eyes/ lazy eye/ amblyopia		
Flashes of light or floating spots in vision		
General Health		
Fever, weight loss, other		
Ear nose throat (sinus infection,dry mouth)		
Cardiovascular (high blood pressure)		
Respiratory (asthma, emphysema,etc.)		
Gastrointestinal (ulcers, intestinal disease)		
Genital, Kidney, Bladder		
Muscles, Bones, Joints (arthritis)		
Skin(acne, warts, skin cancer etc.)		
Neurological (Multiple sclerosis etc.)		
Psychiatric (anxiety, depression, insomnia)		
Endocrine (diabetes, thyroid disorder etc.)		
Blood/lymph (cholestoremia, anemia etc.)		
Allergic/Immunologic (hay fever, lupus etc.)		

Do you smoke? Y N or Do you drink alcohol? Y N

Do you currently wear contact lenses? Y N
What type? _____
If YES are you satisfied with the vision and comfort? Y N
Are you interested in online ordering of contact lenses? Y N

Do you... (check if answer is YES)

_____ work at a computer?
_____ think you may benefit from thinner, lighter lenses?
_____ spend time outdoors?
_____ have prescription sunglasses?
_____ feel comfortable driving at night?
_____ have more than one pair of current Rx glasses?
_____ prefer not to wear your glasses at times?
_____ want information on laser vision correction?

If you wear bifocals, do the lines or head tilting bother you? Y N

Are you interested in the latest high definition lenses? Y N

Thank you for taking the time to fill out this form. Your answers will provide valuable information that will be used to determine proper recommendations for you today.

Jaime Blyskal Marcolini, OD
William R. Marcolini, OD, FAAO
John Hnatyko, OD
Optometric Physicians

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Clinton, NJ 08809
(908) 735-5712
office@clintonfamilyeyecare.com

Washington Family Eyecare
123 W. Washington Ave.
Washington, NJ 07882
(908) 689-1214
office@wfeyecare.com

Child Questionnaire

SOCIAL HISTORY

What grade is your child in?_____ At what school?_____

Hobbies/ Activities_____

Does your child spend time on the computer or use handheld gaming systems if so how many hours per day?_____

Are there any tasks/ activities that your child avoids?_____

VISION HISTORY

Date of your child's last eye exam:_____
Does your child currently wear glasses and/or contact lenses? Y N
If Contact Lenses are worn, what type?_____

Please check any of the following that you have noticed or that your child complains about:

___ Blurred distance vision (Blackboard)
___Blurred near vision (Reading)
___Double Vision
___Eye turns in, out, up, down
___Fatigue during near visual tasks
___Squints or blinks excessively
___Holds book or paper too close
___Words moving or running together
___Frequent headaches
___Eye strain
___Red or teary eyes
___Avoids close work
___Loss of place when reading
___Skips or rereads lines
___Uses finger or under liner to read
___Frequent reversal of letters/ numbers

Was your child born prematurely? Y N
Are there any other concerns that you have about your child's vision or eye health?
_____
_____
_____