**LONGMONT**
2130 Mountain View Ave. #207
Longmont, CO 80501
Tel: 303-772-2755
Fax: 303-772-0104
visionsourcelongmont.com

**FIRESTONE**
6120 Firestone Blvd. #403
Firestone, CO 80520
Tel: 720-966-2020
Fax: 720-966-2021
visionsourcefirestone.com


Today's Date ____________________ Date of last exam ____________________
Main purpose of today's visit ____________________
Name ____________________ Date of Birth ____________________
Address ____________________ Home phone ____________________
____________________ Work phone ____________________
____________________ Cell phone ____________________
Email ____________________

Please check your preferred method of contact:
□ Email □ Cell phone □ Home phone □ Work phone

Employer/school ____________________ Previous eye doctor ____________________
Occupation/grade ____________________ Primary Care doctor ____________________
Parents/spouse ____________________ Their birth date ____________________
Children/siblings ____________________ Their birth date ____________________
Children/siblings ____________________ Their birth date ____________________
Children/siblings ____________________ Their birth date ____________________
Children/siblings ____________________ Their birth date ____________________

How did you hear about our office? ____________________
Please list any vision insurance and provide copy of your card ____________________
Please list any medical insurance and provide copy of your card ____________________
Last four digits of Insured's social security number ____________________

Do you experience any ... (check all that apply):

□ Blurry distance vision
□ Blurry near vision
□ Pain/soreness
□ Glare/reflections
□ Computer eye strain
□ Light flashes
□ Burning
□ Light sensitivity
□ Halos
□ Floaters/spots
□ Trouble focusing
□ Sudden vision loss
□ Redness
□ Watery/teary eyes
□ Double vision
□ Eye irritation
□ Headaches
□ Tired eyes
□ Itching
□ Sandy or gritty feeling

Conditions you or your immediate family have (check all that apply):

**Allergic/immunologic**
□ rheumatoid arthritis
□ lupus
□ other

**Cardiovascular**
□ heart disease
□ hypertension
□ stroke
□ vascular disease
□ other

**Hematologic/Lymph**
□ anemia
□ blood loss
□ leukemia
□ other

**Ears, Nose, Throat**
□ upper resp. tract infection
□ other

**Endocrine**
□ type 2 diabetes
□ type 1 diabetes
□ thyroid dysfunction
□ hormonal dysfunction
□ other

**Neurological**
□ multiple sclerosis
□ epilepsy
□ other

**Gastrointestinal**
□ Crohn's
□ colitis
□ digestive
□ other

**Genitourinary**
□ STD (herpetic, etc)
□ other

**Constitutional**
□ developmental disability
□ weight loss
□ fever
□ other

**Integumentary (skin)**
□ eczema
□ rosacea
□ psoriasis
□ other

**Muskoloskeletal**
□ fibromyalgia
□ muscular dystrophy
□ osteoarthritis
□ ankylosing spondylitis
□ other

**Eyes**
□ glaucoma
□ cataract
□ macular degeneration
□ lazy eye
□ surgery
□ blindness
□ other

**Psychiatric**
□ depression
□ panic disorder
□ schizophrenia
□ other

**Respiratory**
□ cigarettes
□ asthma
□ bronchitis
□ emphysema
□ other

Please list **all** prescription **and** non-prescription medications and reason(s) why taking:
____________________
____________________


DR. JASON L. KAMINSKI
OPTOMETRIST