

# WELCOME TO KISIOLEK EYE CENTER

DR. DAVID W. KISIOLEK

DR. CORINNE S. BEIERSDORF

<p style="text-align: center;"><b>Patient Information:</b></p> <p>Patient's name: _____</p> <p>How do you wish to be addressed? _____</p> <p>Date of Birth: _____ Sex: M F</p> <p>Street Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Home Phone: ( ) _____ Cell Phone: ( ) _____</p> <p>Occupation/ School Grade: _____</p> <p>Firm employed by: _____ Bus. Phone: ( ) _____</p> <p>Has any member of your family been a patient here? If yes, please name: _____</p> <p>To help our office keep more accurate records, please list any family members living at home and any changes _____</p> <p style="text-align: center;"><b>New Patient:</b></p> <p>Whom may we thank for referring you to our office? Friend (Please Name) _____</p> <p>Family physician: _____ Newspaper: _____ Yellow Pages: _____</p> <p>Website: _____ Other: _____</p>	<p style="text-align: center;"><b>Insurance Information:</b></p> <p>Vision Insurance: _____</p> <p>Subscriber Name: _____</p> <p>Subscriber SSN: _____</p> <p>Subscriber Birth Date: _____</p> <p><b>Primary Medical Insurance:</b></p> <p>Subscriber Name: _____</p> <p>Subscriber SSN: _____</p> <p>Subscriber Birth Date: _____</p> <p style="text-align: center;">Do you participate in a flex spending account? Y N</p> <p style="text-align: center;">How do you wish to settle your account today?</p> <p>Cash:      Check:      Master/Visa Card:</p> <p style="text-align: center;"><b>Lifestyle Questions:</b></p> <p style="text-align: center;">Do you.....(check if answer is yes)</p> <p style="text-align: center;">_____work at a computer?</p> <p style="text-align: center;">_____interested in the latest contact lens designs</p> <p style="text-align: center;">_____want information on Laser Vision Correction surgery</p>
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<p style="text-align: center;"><b>Eye Symptoms:</b></p> <p>Please check any of the following that may apply:</p> <p><input type="checkbox"/> Blurry Vision</p> <p><input type="checkbox"/> Eye Infections</p> <p><input type="checkbox"/> Flash of Light</p> <p><input type="checkbox"/> Floaters/Spots</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Itchiness</p> <p><input type="checkbox"/> Eye Pain</p> <p><input type="checkbox"/> Dryness/Grittiness</p> <p><input type="checkbox"/> Sunlight Sensitivity</p> <p><input type="checkbox"/> Trouble seeing at night</p> <p style="text-align: center;"><b>History of Eye Disorder:</b></p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Crossed Eye/EyeTurn/LazyEye</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Macular Degeneration</p> <p><input type="checkbox"/> Retinal Detachment</p> <p><input type="checkbox"/> Eye Injury</p> <p><input type="checkbox"/> Eye Surgery</p> <p><input type="checkbox"/> Other Eye Disorders</p>	<p style="text-align: center;"><b>Patient Medical History:</b></p> <p>Name of Family Physician: _____ Date of Last Physical: _____</p> <p style="text-align: center;"><b>Current Medications:</b></p> <p>List name of medications; including eye drops, vitamins, &amp; birth control pills:</p> <p>_____</p> <p>_____</p> <p>Do you have any known drug allergies? _____</p> <p>Have you ever been diagnosed or treated for the following health problems (please circle):</p> <table style="width: 100%; border: none;"> <tr> <td>Y/N Allergies</td> <td>Y/N High Blood Pressure</td> <td>Y/N Pregnant/Nursing</td> </tr> <tr> <td>Y/N Arthritis</td> <td>Y/N Integumentary (Skin)</td> <td>Y/N Tobacco Use</td> </tr> <tr> <td>Y/N Blood/Lymph</td> <td>Y/N Genitourinary</td> <td>Amount:</td> </tr> <tr> <td>Y/N Bronchitis</td> <td>Y/N Kidney</td> <td>Y/N Alcohol Use</td> </tr> <tr> <td>Y/N Cancer</td> <td>Y/N Muscle/Bone</td> <td>Amount:</td> </tr> <tr> <td>Y/N Diabetes</td> <td>Y/N Neurological</td> <td></td> </tr> <tr> <td>Y/N Digestive</td> <td>Y/N Psychological</td> <td></td> </tr> <tr> <td>Y/N Ears/Nose/Throat</td> <td>Y/N Respiratory</td> <td></td> </tr> <tr> <td>Y/N Endocrine</td> <td>Y/N Sinus</td> <td></td> </tr> <tr> <td>Y/N Eczema/Rashes</td> <td>Y/N Throat Infections</td> <td></td> </tr> <tr> <td>Y/N Fatigue</td> <td>Y/N Thyroid</td> <td></td> </tr> <tr> <td>Y/N Fevers</td> <td>Y/N Unusual weight losses/gains</td> <td></td> </tr> </table>	Y/N Allergies	Y/N High Blood Pressure	Y/N Pregnant/Nursing	Y/N Arthritis	Y/N Integumentary (Skin)	Y/N Tobacco Use	Y/N Blood/Lymph	Y/N Genitourinary	Amount:	Y/N Bronchitis	Y/N Kidney	Y/N Alcohol Use	Y/N Cancer	Y/N Muscle/Bone	Amount:	Y/N Diabetes	Y/N Neurological		Y/N Digestive	Y/N Psychological		Y/N Ears/Nose/Throat	Y/N Respiratory		Y/N Endocrine	Y/N Sinus		Y/N Eczema/Rashes	Y/N Throat Infections		Y/N Fatigue	Y/N Thyroid		Y/N Fevers	Y/N Unusual weight losses/gains	
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<p style="text-align: center;"><b>Patient Eye History:</b></p> <p>Date of Last Eye Exam: _____</p> <p>By Whom? _____</p> <p>Have you ever tried contact lenses? Y/N</p> <p>Do you wear contact lenses now? Y/N</p> <p>What kind? _____</p> <p>Solution used: _____</p> <p>Are you satisfied with the vision and comfort of your contact lenses? Y/N</p>	<p style="text-align: center;"><b>Family Medical/Eye History:</b></p> <p>Is there a family medical history of any of the following?</p> <table style="width: 100%; border: none;"> <tr> <td>Y/N Blindness</td> <td>Y/N Heart Disease</td> </tr> <tr> <td>Y/N Cataracts</td> <td>Y/N Diabetes</td> </tr> <tr> <td>Y/N Corneal Problems</td> <td></td> </tr> <tr> <td>Y/N Lazy Eye</td> <td></td> </tr> <tr> <td>Y/N Glaucoma</td> <td></td> </tr> <tr> <td>Y/N Retinal Problems</td> <td></td> </tr> <tr> <td>Y/N Macular Degeneration</td> <td></td> </tr> <tr> <td>Other Eye Disorder _____</td> <td></td> </tr> </table>	Y/N Blindness	Y/N Heart Disease	Y/N Cataracts	Y/N Diabetes	Y/N Corneal Problems		Y/N Lazy Eye		Y/N Glaucoma		Y/N Retinal Problems		Y/N Macular Degeneration		Other Eye Disorder _____		<p style="text-align: center;"><b>Reviewed Patient History:</b></p> <p>Doctor Signature/ Date</p> <p style="text-align: right; padding-right: 20px;">Dr. Kisiolek #1742 Dr. Beiersdorf #3046</p>
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