



# 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

Replacement Brand \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_

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**