John C. Metzger, OD
Kansas City Vision Performance Center
Vision Therapy • Neuro-Optometry • Low Vision Rehab
10875 Grandview Dr., Ste. 2260, Overland Park, Kansas 66210
(913) 469-8686 www.kcvisionperformance.com

Adult History Form

GENERAL INFORMATION

Today's Date:_____

Full Name	DOB
Preferred Name	
Home Address	
City	State + Zip
Home Phone	
E-mail	
Spouse/Caregiver	Occupation
Cell Phone	Work Phone
E-mail	

Insurance Provider (Please see last page to give this information if you are Original Medicare or BCBS)

REASON FOR VISIT

What brings you to our office?

When did your vision problems begin?

Please describe how your vision has changed?

How does it affect your daily activities?

Have your vision problems changed recently? If yes, please describe.

Are your vision problems hereditary?	Yes	No
Does your vision fluctuate day to day?	Yes	No

FAMILY EYE HISTORY

Please check all symptoms below that apply.

	YES	NO	Please indicate "self" or natural family member (please indicate "maternal" or "paternal" if a grandparent)
Macular Degeneration	____	____	_____
Retinal Detachment	____	____	_____
Cataracts	____	____	_____
Diabetes	____	____	_____
Glaucoma	____	____	_____
Other:	____	____	_____

SYSTEMS REVIEW

NEUROLOGICAL	**YES**	**NO**	**EYES**	**YES**	**NO**
Headaches / Migraines	____	____	Blurred Vision (with glasses)	____	____
Seizures	____	____	Distorted Vision / Halos	____	____
Dizziness / Balance	____	____	Loss of Side Vision	____	____
Memory	____	____	Double Vision (Separate Images)	____	____
Processing Difficulty	____	____	Dryness	____	____
Concentration	____	____	Itching / Burning	____	____
EARS, NOSE, MOUTH, THROAT			Eye Pain / Soreness	____	____
Allergies / Hay Fever	____	____	Flashes of Light in Vision	____	____
Hearing Sensitivity	____	____	Floaters (Specks or "Cobwebs")	____	____
Imbalance	____	____	Eye Injury	____	____
RESPIRATORY			**CARDIOVASCULAR**		
Asthma			High Blood Pressure	____	____
Emphysema	____	____	Chest Pains	____	____
COPD	____	____	Shortness of Breath	____	____
BONES, JOINTS, MUSCLES			Swelling of Legs	____	____
Arthritis	____	____	Palpitations / Faintness	____	____
PHYCHIATRIC			**SKIN**		
Depression / Mood Swings	____	____	Irritations	____	____
Anxiety	____	____	Growth / Moles	____	____

SURGERY, ACCIDENTS, ILLNESS

Please describe any EYE surgeries, treatments, or medications you have had or currently use.

Please share any illnesses, injuries, or surgeries you have recently had.

OVERALL HEALTH

Please describe your overall current health.

On a scale of 1 to 10, how would you rate your overall health? (10 = Excellent)

On a scale of 1 to 10, how would you rate your overall visual performance? (10 = Excellent)

American *Recovery* and Reinvestment Act (ARRA) Information Requested:

(This information is optional. These categories are requested by the federal government):

Race: ___ African American or Black___ American Indian/Alaskan Native___ Asian ___ Native Hawaiian/Pacific Islander ___ White___ Other ___ Declined

Preferred Language: ___ English, ___ Spanish, Other:_____ ___ Declined

Ethnicity: ___ Hispanic or Latino, ___ Not Hispanic or Latino ___ Declined

Smoking Status: ___Current Everyday Smoker ___Current Some Day Smoker ___Former Smoker ___Never Smoker ___ Smoker, Status Unknown ___ Unknown If Ever Smoked

Received Influenza Immunization: ___ Yes ___ No ___ Declined

RELEASE

The doctor in our clinic does not perform primary-care eye health exams. We do recommend that you have an eye health exam yearly by a primary-care optometrist or ophthalmologist. If we require you to have this exam prior to your visit with our doctor we will let you know. If you would like a list of primary care optometrists or ophthalmologists please let us know.

I understand that the doctor will not be assessing my eye health in the course of this evaluation. I further understand that it is recommended that I have an eye health examination yearly by a primary-care optometrist or ophthalmologist. I agree to allow Kansas City Vision Performance Center to send the records from my exam to my primary care optometrist or ophthalmologist. If you have not had a primary eye health exam the previous sentence is not applicable.

_____ _____

Patient Signature **Date**

Insurance Information

We only participate in BlueCross BlueShield and Original Medicare (plus your Insurance Supplement).

Patient Name

Subscriber Name

Subscriber DOB

Relationship to Patient

Primary Insurance Plan

Primary Subscriber ID#

Secondary Insurance Plan

Secondary Subscriber ID#

Is Subscriber Billing Address the same as the Patient Billing Address? Yes No

If No, please enter Subscriber Billing Address

Address

City State + Zip