

John C. Metzger, OD, LLC
KC Vision Performance
Vision Therapy • Neuro-Optometry • Low Vision Rehab
10875 Grandview Dr., Ste. 2260, Overland Park, Kansas 66210
(913) 469-8686 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
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Does your vision fluctuate day to day?	Yes	No
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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	_____	_____
PSYCHIATRIC			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
