Dr. Jan W. Nyssen

"Welcome to our office."

1. NAME: ____DATE OF BIRTH: ____/____/_____ AGE: _____

2. ADDRESS: ____CITY___________________________

3. STATE: _________________ZIP: _____________E-MAIL ADDRESS____________________________________

4. CELL #: ______________________ WORK #: _______________________ HOME #: _______________________

5. OCCUPATION: __________________________________EMPLOYER: ___________________________________

6. HOW WERE YOU REFERRED TO US? ____

7. HOW LONG HAS IT BEEN SINCE YOUR LAST EXAMINATION? _______________________________________

8. INSURED INFORMATION:

NAME_____________________________ SOCIAL SECURITY #_________/________/___________

DATE OF BIRTH____________________ INSURANCE THROUGH: VSP EYEMED OTHER

9. MY EXAM IS FOR (CHECK ALL THAT APPLY): ☐ ROUTINE EXAM ☐ GLASSES ☐ SUNGLASSES ☐ CONTACT LENSES ☐ REFRACTIVE SURGERY ☐ OCCUPATIONAL EYEWEAR ☐ SPORTS EYEWEAR

10. WOULD YOU LIKE TO LEARN MORE ABOUT LASIK SURGERY? ☐ YES ☐ NO

11. MY CHIEF VISUAL COMPLAINT IS: ____

12. MY HOBBIES INCLUDE: ☐ RACQUETBALL ☐ TENNIS ☐ GOLF ☐ SKIING ☐ FISHING ☐ SEWING ☐ COMPUTERS ☐ BOATING ☐ OTHER ____________________________________

13. DO YOU UTILIZE A COMPUTER AT HOME OR WORK? ☐ YES ☐ NO ☐ BOTH

14. LIST ANY MEDICATIONS YOU ARE TAKING: ____
____

15. LIST ANY ALLERGIES, INCLUDING THOSE TO MEDICATIONS: _____________________________________

HEALTH HISTORY
(CHECK ALL THAT APPLY)

	PERSONALLY	**FAMILY MEMBERS**
17. DIABETES	☐	☐
18. GLAUCOMA	☐	☐
19. OTHER EYE DISEASES/ SURGERIES	☐	☐
20. HIGH BLOOD PRESSURE	☐	☐
21. HEART DISEASE	☐	☐
22. THYROID CONDITION	☐	☐

PLEASE PRINT & FILL OUT FORM AND BRING IN TO EXAM APPOINTMENT, THANK YOU.