PEAK VISION

Dr. Steve Belanger
Dr. Dale G Lervick

NAME: _______________________________ **Date of Birth:** __________________
Address (if new patient or changeyu)____
Email ______________________ **Phone**____________**Occupation**____________
SS#insured___________________**Insurance**________________________________
Reason for today's visit:____
Date of last visit to eye doctor: _______ **Employer**______________________

What are your visual symptoms? (circle all that apply)
Blurry Vision-Distance   Burning Eyes   Floaters or Spots   Headaches   Eye Injury
Blurry Vision-Near   Itchy Eyes   Seeing Flashes   Migraine Headaches   Double Vision
Dry Eyes   Poor Night Vision   Crossed/Turned Eyes Eye Strain   Red Eye(s)
Light Sensitivity Eye Infection Watery Eyes Sandy/Gritty Feeling   Droopy Lid   Eye Pain

Do you wear glasses? Yes No All the time/ Sometimes / Work/School Only/ Reading/Driving
Do you wear contact lenses? Yes No Type: _____________________________
Do you smoke? Yes No **Are you pregnant? Yes No**
List current MEDICATIONS (or provide list):
____
List ALLERGIES to meds or other_______________________________________
DISEASE HISTORY: SELF or FAMILY Please write who or discuss w Dr
Glaucoma ____________**Cataracts** _____________**Eye Surgery**______________
Macular Degeneration ____________ **Retinal Detachment** _______________
Crossed or Lazy Eye _______________**Other Eye Disease** ________________
Diabetes A1c: _____________________ **Heart Disease**______________________
High Blood Pressure ________**MultipleSclerosis**_________**Arthritis**_______
Asthma ______________ **Lupus**___________ **Cancer**______________________
OTHER:____
PLEASE SIGN both lines (more on file, ask if not understood)
We respect HIPPA to keep your health information private
I understand ____**Date**______________
Insurance Release to Peak Vision and finance policy___________________