

**Precision Cataract & Laser Center, LLC**  
**Spring Hill Eye Center**

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Thank you for selecting the Spring Hill Eye Center for your vision and eye care needs.

Please complete the following patient information and history forms and bring them with you at the time of your appointment. This will give us a brief background on you and your visual history.

If you have insurance, we will need to make copies of your insurance cards for your file.

If you are currently wearing eyeglasses, please bring in your most recent pair of glasses.

If you are a contact lens wearer, please wear your glasses into the office. Bring your contacts and information regarding the type and powers in with you.

Your eyes will be sensitive to light so we suggest you bring sunglasses to wear after your exam. If you do not have any, just ask and we will provide some for you.

We are located approximately one block west of Mariner on Spring Hill Drive. Just look for the green and white sign that reads DOCTORS BUILDING.

We look forward to seeing you!

# Lifestyle Questionnaire

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_

This questionnaire is designed to assist you and your eyecare professional in helping select the best lenses, frames and/or contact lenses to suit your visual needs and lifestyle.

1. Which of the following visual demands do you encounter on a regular basis?  
(check all that apply)

- |   |  |   |
|---|--|---|
| <input type="radio"/> Artificial lighting | <input type="radio"/> Computer Work    | <input type="radio"/> Potential Eye Hazards |
| <input type="radio"/> Board work          | <input type="radio"/> Natural lighting | <input type="radio"/> Reading               |
| <input type="radio"/> Close-up work       | <input type="radio"/> Paperwork        | <input type="radio"/> Other:                |

2. Which of the following hobbies or activities do you participate in?  
(check all that apply)

- |  |   |  |
|--|---|--|
| <input type="radio"/> Auto repair          | <input type="radio"/> Fishing               | <input type="radio"/> Reading            |
| <input type="radio"/> Biking               | <input type="radio"/> Golf                  | <input type="radio"/> Sewing/arts/crafts |
| <input type="radio"/> Boating/water sports | <input type="radio"/> Home repairs          | <input type="radio"/> Snow sports        |
| <input type="radio"/> Bookkeeping          | <input type="radio"/> Hunting/shooting      | <input type="radio"/> Spectator sports   |
| <input type="radio"/> Bowling              | <input type="radio"/> Jogging/running       | <input type="radio"/> Tennis             |
| <input type="radio"/> Competitive sports   | <input type="radio"/> Landscaping/gardening | <input type="radio"/> Watching TV        |
| <input type="radio"/> Computer             | <input type="radio"/> Musical instrument    | <input type="radio"/> Welding            |
| <input type="radio"/> Drawing              | <input type="radio"/> Painting              | <input type="radio"/> Woodwork           |
| <input type="radio"/> Driving              | <input type="radio"/> Pilot                 | <input type="radio"/> Other:             |
| <input type="radio"/> Exercise             | <input type="radio"/> Racquetball           |  |

3. Do your eyes seem bothered by glare from any of the following situations?

- |  |                                     |                                      |
|--|-------------------------------------|--------------------------------------|
| <input type="radio"/> Car headlights     | <input type="radio"/> Haze          | <input type="radio"/> Traffic lights |
| <input type="radio"/> Computer monitor   | <input type="radio"/> Night driving | <input type="radio"/> Other:         |
| <input type="radio"/> Fluorescent lights | <input type="radio"/> Sunshine      |                                      |

4. Do you have any metal or silicon allergies?    Yes            No

5. Do you currently wear glasses ( Yes No ) or contacts ( Yes No )?

If Yes: What do you like about your current glasses or contacts (color, style, fit)

\_\_\_\_\_

What don't you like about your current glasses or contacts (weight, thickness, glare, etc)

\_\_\_\_\_

6. If you wear contacts, do you have:

- Current pair of prescription glasses
- Sunglasses (purchased at a boutique, department / optical store)

# WELCOME TO THE SPRING HILL EYE CENTER

PLEASE PRINT

DATE \_\_\_\_\_

Patient's Name  
Mr. Mrs. Ms. \_\_\_\_\_

Spouse or Legal Guardian \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone-Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Sex \_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

PRIMARY INSURANCE CO: \_\_\_\_\_

ID# \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

SECONDARY INSURANCE CO \_\_\_\_\_

ID# \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

VISION INSURANCE CO \_\_\_\_\_

ID# \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

\*\*\*\* We will need to make copies of your insurance cards\*\*\*\*

Date of Last Exam \_\_\_\_\_ Reason for Today's Visit \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_ How old are they? \_\_\_\_\_

Are you interested in wearing contacts? \_\_\_\_\_ What name do you prefer we call you? \_\_\_\_\_

Would you like to receive your appointment recall notice by e-mail? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide your e-mail address \_\_\_\_\_

\*\*\*PLEASE NOTE – EXAMINATIONS MUST BE PAID FOR AT TIME OF VISIT  
UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

\*\*\*\*ALL PATIENTS PLEASE READ AND SIGN\*\*\*\*

I am responsible for all financial obligations for any services provided for the above named patient, and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, interest charges, collection costs and reasonable legal fees, including reasonable attorneys' fees.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\*\*MEDICARE/PPO/HMO/VISION PLAN PATIENTS PLEASE READ AND SIGN\*\*

I request that payment of authorized insurance benefits be made either to Dr. Fredrick Weinberg, Dr. Dennis Williams, or Dr. Ian Jung, for any services provided to me, I authorize the release of any medical information needed to determine these benefits or the benefits payable for related services to my Insurance company or the Health Care Financing Administration and it's agents (Medicare).

Patient's Signature \_\_\_\_\_

\* \* \* \* \*

Please take a moment to let us know how you were referred to us:

Yellow Pages \_\_\_\_\_ Clinic Sign \_\_\_\_\_ TV Ad \_\_\_\_\_ Newspaper \_\_\_\_\_ Internet \_\_\_\_\_

Chamber of Commerce \_\_\_\_\_ Ins.: VSP/VCP \_\_\_\_\_ Other Ins Plan \_\_\_\_\_ Employer \_\_\_\_\_

Physician: (name) \_\_\_\_\_

Friend/Relative (name) \_\_\_\_\_

Other Referral Source \_\_\_\_\_

SPRING HILL EYE CENTER  
PATIENT HISTORY QUESTIONNAIRE

DATE \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
Family Physician \_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_

PAST MEDICAL HISTORY

YES NO

- \_\_\_\_ Anemia
- \_\_\_\_ Angina
- \_\_\_\_ Arrhythmia
- \_\_\_\_ Arthritis
- \_\_\_\_ Asthma
- \_\_\_\_ Bronchitis
- \_\_\_\_ Claustrophobia
- \_\_\_\_ Congestive Heart
- \_\_\_\_ Diabetes
- \_\_\_\_ Emphysema
- \_\_\_\_ Heart Attack
- \_\_\_\_ Heart Disease
- \_\_\_\_ Hiatal Hernia
- \_\_\_\_ High Blood Pressure
- \_\_\_\_ Kidney Disease
- \_\_\_\_ Liver Disease
- \_\_\_\_ Phlebitis
- \_\_\_\_ Pneumonia
- \_\_\_\_ Rheumatic Fever
- \_\_\_\_ Stroke
- \_\_\_\_ Thyroid
- \_\_\_\_ Tuberculosis
- \_\_\_\_ Other

REVIEW OF SYMPTOMS

Do you have these now?

YES NO

- \_\_\_\_ Hearing Loss \_\_\_\_\_
- \_\_\_\_ Dizziness/Fainting \_\_\_\_\_
- \_\_\_\_ Dentures \_\_\_\_\_
- \_\_\_\_ Shortness of Breath \_\_\_\_\_
- \_\_\_\_ Cough \_\_\_\_\_
- \_\_\_\_ Wheezing \_\_\_\_\_
- \_\_\_\_ Chest Pain \_\_\_\_\_
- \_\_\_\_ Skipped beats/palpitation \_\_\_\_\_
- \_\_\_\_ Ulcers/abdominal pain \_\_\_\_\_
- \_\_\_\_ Swelling in Feet \_\_\_\_\_
- \_\_\_\_ Leg Cramps \_\_\_\_\_
- \_\_\_\_ Tremor \_\_\_\_\_
- \_\_\_\_ Difficulty lying flat \_\_\_\_\_

PRESENT PRESCRIPTION MEDICATIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITALIZATIONS

List prev hosp and surgeries

Thyroid/neck \_\_\_\_\_  
Heart \_\_\_\_\_  
Lung \_\_\_\_\_  
Stomach/abdomen \_\_\_\_\_  
Other \_\_\_\_\_

ALLERGIES

\_\_\_\_\_ No Known Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY

Diabetes Y/N Relation \_\_\_\_\_  
Heart Disease Y/N Relation \_\_\_\_\_  
High Blood Pressure Y/N Relation \_\_\_\_\_  
Macular Degeneration Y/N Relation \_\_\_\_\_  
Cataracts Y/N Relation \_\_\_\_\_  
Glaucoma Y/N Relation \_\_\_\_\_  
Retinal Detachment Y/N Relation \_\_\_\_\_  
Other Eye Conditions \_\_\_\_\_

PERSONAL EYE INFORMATION

Surgeries Y/N Type/Date \_\_\_\_\_  
\_\_\_\_\_  
Injuries Y/N Kind/Date \_\_\_\_\_  
\_\_\_\_\_

UPDATED ON/BY

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SOCIAL HISTORY

Alcohol Use : \_\_\_ Never \_\_\_ Rare \_\_\_ Mod \_\_\_ Daily  
Tobacco Use: \_\_\_ Never \_\_\_ Yr Quit \_\_\_ Curr. Pks/Day \_\_\_  
Drug Use : \_\_\_ Never \_\_\_ Type/freq \_\_\_\_\_