PREMIER VISION
OPTOMETRY

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions./ 請盡您所能回答所有問題

PATIENT INFORMATION /病人資料			
First Name/名字:	Patient's Last Name /姓:	Sex/性別: ❑ M/男 ❑ F/女 Age/年齡:	Birth Date /出生日期: / /
Occupation/職業:	Employer/雇主:	Social Security No./ 社會安全號碼::	
Street Address/地址:	City/城市:	State/ 州:	ZIP Code/郵政編碼:
Home Phone No./電話號碼:	Work Phone No./工作電話:	Cell Phone No./ 手機:	
E-mail/電子郵件:	How did you hear about us/介紹人:		
Emergency Contact Name & Phone No./緊急聯絡人姓名及電話:			

INSURANCE INFORMATION/保險資料					
Insurance Card/ID No./ 保險號碼:					
Type of Insurance/保險類別:	❑ VSP	❑ EyeMed	❑ MES	❑ Medicare	❑ BlueCross PPO
Name of Insured/被保險人姓名:	SSN of Insured/被保險人社會安全號碼:	Birth Date of Insured/被保險人出生日期: / /			
Relationship to insured/ 與保險人的關係:	❑ Self/自己	❑ Spouse/配偶	❑ Child/孩子	❑ Parent/家長	❑Other (specify)/ 其他(註名):

NOTE: INSURANCE CARD AND CO-PAYMENT MUST BE PRESENT AT TIME OF SERVICE.

MEDICAL INFORMATION/病人醫療資料		
Allergies/過敏: _____ ❑ None/無	Ocular History/眼科歷史: _____ ❑ None/無	❑ Pregnant/懷孕 ❑Wear glasses/戴眼鏡 ❑Wear contact lenses/戴隱形眼鏡
Medication/藥物: _____ ❑ None/無	Injuries or Surgeries/手術: _____ ❑ None/無	❑Soft/軟式 ❑ Hard/硬式 ❑ Comfortable/舒適

Social History/個人生活的歷史
❑ Doesn't Drive/不開車 ❑ Drive/開車 Driving Difficulties/駕駛困難:
❑ Doesn't use Tobacco/不抽煙 ❑ Use Tobacco/抽煙 Type/Amt/How long/類型，數量，多久:
❑ Doesn't Drink Alcohol/不喝酒 ❑ Drink Alcohol/喝酒 Type/Amt/How long/類型，數量，多久:
❑ Doesn't Use Illegal Drugs/不使用非法藥品 ❑ Use Illegal Drugs/使用非法藥品 Type/Amt/How long/類型，數量，多久:

Premier Vision Optometry Policy / 退款規定
No refunds allowed. Store credit only. /出售的商品嚴格不予退款. 予店內消費金額而非現金
_____ _____ Patient/Guardian Signature/病人或監護人簽名 Date/日期

PREMIER VISION OPTOMETRY

PERSONAL Review of Systems. Please check all that apply to you/請選擇所有你有的病症或問題

EYES/ 眼睛
- ❑ Vision Loss/視力喪失
- ❑ Blurry Vision/視力模糊
- ❑ Distorted Vision/視覺扭曲
- ❑ Double Vision/重視
- ❑ Dryness/乾眼
- ❑ Redness/紅眼
- ❑ Mucous Discharge/粘液排放
- ❑ Gritty Feeling/沙粒的感覺
- ❑ Itching/癢的感覺
- ❑ Burning/燒灼的感覺
- ❑ Excess Watering/過量出水
- ❑ Light Sensitivity/光敏感
- ❑ Eye Pain or Soreness/眼痛或酸痛
- ❑ Chronic Infection/慢性感染
- ❑ Flashes/閃爍
- ❑ Floating Spots/漂浮點
- ❑ Tired Eyes/眼睛疲倦
- ❑ Cataracts/白內障
- ❑ Diabetic Retinopathy/糖尿病性視網膜病變
- ❑ Glaucoma/青光眼
- ❑ Macular Degeneration/黃斑變性
- ❑ Retinal Detachment/視網膜脫離

GASTROINTESTINAL/ 胃腸道
- ❑ Colitis/結腸炎
- ❑ Crohn's Disease/節段性回腸炎病
- ❑ Ulcers/潰瘍
- ❑ Constipation/便秘
- ❑ Diarrhea/腹瀉

CONSTITUTIONAL/全身的
- ❑ Fever/發燒
- ❑ Weight Loss or Gain/體重變化
- ❑ Fatigue/疲勞
- ❑ Trauma/創傷

INTEGUMENTARY (SKIN)/ 外皮的
- ❑ Eczema/濕疹
- ❑ Rosacea/酒渣鼻
- ❑ Psoriasis/ 疥瘡

NEUROLOGIC/ 神經
- ❑ Headaches/頭痛
- ❑ Migraines/偏頭痛
- ❑ Seizures/癲癇
- ❑ Mult.Sclerosis/多發性硬化症

ENDOCRINE/ 內分泌
- ❑ Non Insulin Diabetes /非胰島素糖尿病
- ❑ Insulin Diabetes/胰島素糖尿病
- ❑ Thyroid Dysfunction/甲狀腺功能減退
- ❑ Hormonal Dysfunction/荷爾蒙功能減退

RESPIRATORY/ 呼吸
- ❑ Asthma/ 氣喘
- ❑ Bronchitis/支氣管炎
- ❑ Emphysema /氣腫

CARDIOVASCULAR /心血管
- ❑ Heart Disease/心臟疾病
- ❑ Hypercholesterolemia/高膽固醇血症
- ❑ Hypertension/高血壓

EARS/NOSE/THROAT / 耳/ 鼻/ 喉
- ❑ Allergies/過敏
- ❑ Sinus Congestion/鼻竇充血
- ❑ Runny Nose/流鼻涕
- ❑ Post Nasal Drip/鼻滴水
- ❑ Chronic Cough/慢性咳嗽
- ❑ Dry Throat/Mouth/咽喉乾燥

ALLERGIC/IMMUNE / 過敏/免疫
- ❑ Drug Allergies/藥物過敏
- ❑ Seasonal Allergies/季節性過敏
- ❑ Lupus/狼瘡
- ❑ Arthritis/關節炎

LYMPHATIC/HEMATOLOGIC/ 淋巴/血液
- ❑ Anemia/貧血
- ❑ Bleeding Problems/出血問題
- ❑ Leukemia/白血病

MUSCULOSKELETAL/ 肌肉骨骼
- ❑ Fibromyalgia/纖維肌痛
- ❑ Muscular Dystrophy/肌肉萎縮症
- ❑ Osteoarthritis/骨性關節炎
- ❑ Ankylosing Spond./ 強直性脊柱炎

GENITOURINARY/ 泌尿生殖系
- ❑ Kidney problems/腎臟問題
- ❑ Bladder problems/膀胱問題
- ❑ STDs/性病
- ❑ Other/其他

FAMILY Medical History: Note relation to yourself (example: "mother")/家庭成員醫療資料, 请注明和自己的關係 (例如:母親)

- ❑ Blindness/失明
- ❑ Cataracts/白內障
- ❑ Macular degeneration/黃斑變性
- ❑ Glaucoma/青光眼
- ❑ Retinal detachment/視網膜脫離
- ❑ Crossed Eyes/鬥雞眼
- ❑ Lupus/狼瘡
- ❑ Other/其他
- ❑ Cancer/癌症
- ❑ Lupus/狼瘡
- ❑ Heart Disease/心血管疾病
- ❑ High Blood Pressure/高血壓
- ❑ Kidney Disease/腎臟病
- ❑ Arthritis/關節炎
- ❑ Thyroid Disease/甲狀腺疾病
- ❑ None/無

DISCLAIMER/聲明

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment of all services or materials provided to me. I also authorize Premier Vision Optometry to release any information required to process my claims.
上述信息是真實的。我知道，我將負責支付所有提供給我的服務或材料。我還授權 *Premier Vision Optometry* 釋放任何所需資料以便處理我的保險索賠。

Patient/Guardian Signature/病人或監護人簽名 _____ Date/日期 _____