



Dr. Jeffrey W. Sanger
 Dr. Melinda K. Kennel
 408 South 8th Avenue
 Broken Bow, NE 68822

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name _____
 Maiden /Former Name _____
 Street _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____
 Cell Phone _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Social Security # _____

MEDICAL HISTORY					
Allergies	No	Yes	Arthritis	No	Yes
Asthma	No	Yes	Cancer	No	Yes
Skin Disorder	No	Yes	Diabetes	No	Yes
Eye Diseases	No	Yes	Heart Disease	No	Yes
Eye Injury	No	Yes	H.B. Pressure	No	Yes
Eye Surgery	No	Yes	Thyroid	No	Yes
Lazy Eye	No	Yes	Kidney	No	Yes
Cataracts	No	Yes	Nerves	No	Yes
Glaucoma	No	Yes	Other _____		

CURRENT MEDICATIONS (Rx OR OVER THE COUNTER)		
Antihistamines	No	Yes _____
Diuretics (Water Pills)	No	Yes _____
Blood Pressure Pills	No	Yes _____
Oral Contraceptives	No	Yes _____
Sleeping Tablets	No	Yes _____
Eye Drops	No	Yes _____
Other _____		

Are you currently under the care of a physician? No Yes
 Name of physician _____

FAMILY MEDICAL HISTORY			Relationship
Blindness	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____

Date of Birth _____ Age _____ Sex: M ___ F ___

What is the major purpose of this visit? _____

Any problems with your present contact lenses or glasses?

Spouse (or Parent's Name) _____

Spouse (or Parent's Work Phone) _____

Do you...

..Work at a computer for long periods?	___ Yes	___ No
..Have more than one pair of glasses?	___ Yes	___ No
..Want more information on thinner, lighter lenses?	___ Yes	___ No
..Wear bifocals?	___ Yes	___ No
..(If yes, are you bothered by head tilting, restricted areas of vision correction, etc.?)	___ Yes	___ No
..Always like to wear your glasses?	___ Yes	___ No
..Spend time outdoors? (how much?)	___ Yes	___ No
..Have prescription sunglasses?	___ Yes	___ No
..Have problems with glare or reflection?	___ Yes	___ No
Particularly when driving at night?	___ Yes	___ No
..Have family members in need of Eyecare?	___ Yes	___ No

Have you ever worn/are you currently wearing contacts? or glasses?
 ___ Yes ___ No
 What kind? _____ Solutions used _____

Are you interested in contact lenses? ___ Yes ___ No

Do you experience...

___ Burning	___ Spots	___ Uncomfortable glasses
___ Itchiness	___ Soreness	___ Sudden loss of vision
___ Nausea	___ Flashes of light	___ Sensitivity to light
___ Watery eyes	___ Headaches	___ Fainting or dizziness
___ Tearing	___ Redness	___ Blurry distance vision
___ Dryness	___ Double vision	___ Blurry near vision
___ Eye strain		___ Gritty feeling in eyes
___ Reading problems		___ Objects floating in vision
___ Glare or reflection		___ Trouble seeing at night
___ Uncomfortable contact lenses		___ Trouble reading or learning
___ Trouble working up-close		at work, school, or activity

Did your school provide you with a Vision Report Card? ___ Yes ___ No
 Other: _____

Vision Insurance: _____

Medical Insurance: _____

Policy Holder's Name _____ Date of Birth _____

How will you settle your account today?

___ Check ___ Cash ___ Credit Card

AUTHORIZATIONS

I am responsible for payment of this account in full at the time services are rendered unless previous arrangements have been made. I understand there will be a rebilling charge of 16% per annum added on any balance over 60 days. Above authorizations pertain to all charges incurred hereafter

Signature _____ Date _____

(over)

Today's Date _____ Date of Last Exam _____