8007 W. 151st St.

Overland Park, KS 66223

Text or Call: 913-681-2624

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Gender:
○ Female ○ Male
○ They/Them ○ Other

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email (for patient portal access): _____

Ok to contact me via:
☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email

2. How did you learn about our practice?

☐ Insurance ☐ Google ☐ Social Media
☐ Referral ☐ Walked by ☐ Previous patient

Other: _____

3. Whom may we thank for referring you to Blue Valley Vision of Overland Park on 151st?

_____

4. Check if you currently have or have ever had any of the following:

- ☐ NONE of the following
- ☐ UNKNOWN
- ☐ Cancer
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tumor
- ☐ Stroke
- ☐ Migraine
- ☐ Anxiety
- ☐ Depression
- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Crohn's / Colitis
- ☐ Acid Reflux
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Rosacea
- ☐ Herpes Simplex / Cold Sores
- ☐ Herpes Zoster / Shingles
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid problems
- ☐ Hormonal Dysfunction
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Lupus
- ☐ Sjogrens Syndrome

Other

_____

5. Are you currently:

- ○ Pregnant
- ○ Nursing
- ○ Unknown
- ○ Not applicable
- ○ None

6. Are you currently taking ANY medications?

- ○ YES
- ○ NO

7. List medications you are currently taking and the correlating dosages:

	Medication	Dosage
1		
2		
3		
4		

8. Do you have allergies to any of the following

- ○ NONE
- ○ Medications
- ○ Latex
- ○ Environmental
- ○ Seasonal
- ○ Other

9. Please list your allergies here.

	Allergy
1	
2	
3	
4	

10. Check if you currently have or have ever had any of the following EYE conditions:

- ☐ NONE of the following
- ☐ UNKNOWN
- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Eye Surgery
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal Detachment
- ☐ Retinal Hole / Tear
- ☐ Keratoconus
- ☐ Eye Injury / Trauma
- ☐ Dry Eye
- ☐ Nystagmus
- ☐ Ocular Shingles

Other

_____

11. Please indicate information about your social history.

Drinking
○ Daily ○ Socially ○ Former ○ Never ○ Unknown
○ Refuse to answer

Tobacco Use
○ Daily ○ Socially ○ Former ○ Never ○ Unknown
○ Refuse to answer

Exposed to or Infected with:
○ NONE ○ HIV ○ Syphilis ○ Gonorrhea
○ Hepatitis ○ Refuse to answer

Other recreational drugs (list below)

_____

_____

12. Check the box if any of your relatives, living or deceased, had any problems with the following conditions.

	FATHER	MOTHER	SIBLING	CHILD	UNKNOWN	NONE
Arthritis						
Cancer						
Diabetes						
Hypertension						
Thyroid						
Heart Disease						
High Cholesterol						
Amblyopia						
Macular Degeneration						
Cataract						
Glaucoma						
Keratoconus						
Legal Blindness						
Retinal Detachment						

Other

_____

13. Please upload a photo of your insurance cards (FRONT AND BACK)

Add additional information you find relevant

_____

14. Do you have a cough?

○ YES
○ NO

15. Do you have a fever now or have you in the past 14-21 days?

- YES
- NO

16. Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?

- YES
- NO

17. Are you experiencing shortness of breath or difficulty breathing?

- YES
- NO

18. Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

- YES
- NO

19. Have you experienced recent loss of taste or smell?

- YES
- NO

20. Are you over the age of 60?

- YES
- NO

21. Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?

- YES
- NO

22. Have you traveled in the last 14 days to any regions affected by COVID-19 (as relevant to your location)?

- YES
- NO

By signing below, I agree that I have read and understand the above and have voluntarily answered all questions truthfully and to the best of my ability.

_____ _____

Signature Date