# Family Vision Solutions – Patient Update Form

| | |
|---|---|
| **Date:** | **Name:** |
| **Current Age:** | **Occupation:** _____<br>**Employer:** _____ |
| **Health History:**<br>***Please Indicate***<br>***S=Self***<br>***F=Family*** | □ __Blurred Vision □ __Glaucoma □ __Cataracts □ __Dry Eyes □ __Macular Degeneration □ __Retinal Detachment □ __Strabismus<br>□ __Hypertension □ __Heart Disease □ __Diabetes □ __Cancer □ __Arthritis □ __Lupus □ __Thyroid<br>□ __Kidney □ __Nerves □ __Asthma □ __Anemia □ __Other: _____ |
| **Please List All Medications Currently Taken Including Over-the-Counter**<br>□ **LIST ATTACHED** | _____ _____ _____<br>_____ _____ _____<br>_____ _____ _____ |
| **Allergies to Medications**<br>□ **No Known Drug Allergies** | _____ _____ _____ |
| **PHARMACY INFORMATION** | NAME: _____ PHONE: _____ |
| **Social History**<br>*This information is kept strictly confidential. You may discuss this directly with your doctor if you prefer.* | **Do you use tobacco products?** __Yes __No<br>*If yes:*<br>Type: _____<br>Amount: _____<br>How Long: _____<br>**Do you drink alcohol?** __Yes __No<br>*If yes:*<br>Type: _____<br>Amount: _____<br>How Long: _____ |
| **Emergency Contact**<br>□ **OK TO SHARE INFO** | _____ _____ _____<br>Name Relationship Phone Number |
| **Names of Other Person(s) With Whom We Can Share Your Health or Other Account Information** | ***Please include anyone who might call to make/change appointments or order contacts:***<br>Name: _____ Relationship: _____<br>Name: _____ Relationship: _____ |
| **Preferred Phone Number**<br>□**Home** □**Work** □**Cell** | ***Please initial to grant permission to leave voice message on the phone number listed here:***<br>Phone: _____ Initials: _____ |
| **Text Messaging** | ***Authorization for confirmation messages and other communications:*** Initials: _____ |
| **Request for E-Mail Communication** | *I hereby acknowledge that e-mail between Family Vision Solutions and me is not encrypted and therefore not guaranteed to be private. I request Family Vision Solutions to accept and respond to e-mails from me, and grant permission for Family Vision Solutions to send newsletters, appointment confirmations, prescriptions and other requested Private Health Information via e-mail.*<br>***I will notify Family Vision Solutions of any changes to my E-Mail listed here:***<br>E-Mail: _____<br>Signature: _____ |

PHONE 713.349.0224 FAX 713.349.9834 5177 RICHMOND AVENUE, SUITE 780; HOUSTON, TX 77056-6752
WWW.FAMILYVISIONSOLUTIONS.COM