BROADVISION
EYE CLINIC

P O Box 30338
Metsef, Francistown
Botswana

Primary Eye Care
Contact Lenses

Tel: +267 2406540
Fax: +267 2410998
Cell: +267 74164548
Email: info@broadoptoms.com

Patient Information

PLEASE PRINT CLEARLY Today's Date_____
Last Name _____First Name _____M.I._____
Title: Dr./ Mr./ Mrs./ Ms./ Rev./ Judge Nickname:
Address: _____
City: Country: _____ _____
Home Phone (_____) Daytime Phone (___) _____
Cell Phone ( ) Email
Primary influence for selecting our practice:
Referred by _____

Internet/Website
Walk-In
Other
Gender: M F Date of Birth _____ Age
Identity Number_
Marital Status: Married / Divorced/ Single/ Widow(er)/ Domestic Partner
Employer or School:
Occupation:

Principal member Insurance to File
MA/#
Name _____ DOB _____Relationship to patient ___
ID# _____ _____
Medical Aid Name Phone#
Address _____

Dependant(s) Insurance to File
MA/ # _____
Name _____ Relationship to patient_____
ID# _____ _____
Medical Aid Name _____ Phone # __
Address _____

Guarantor Information (Who will be responsible for this account?)
Check here if same as above or

BROADVISION
EYE CLINIC

P O Box 30338
Metsef, Francistown
Botswana

Primary Eye Care
Contact Lenses

Tel: +267 2406540
Fax: +267 2410998
Cell: +267 74164548
Email: info@broadoptoms.com

Name _____ Relationship to patient_____
Address City _____
Home phone # (_____)_____Cell Phone (_____) _____

All patients please read and sign below

I authorize Broadvision Eye Clinic to release any medical information to my Medical Aid company (or companies) and to accept assignment of benefits. I understand that I may have co-payments and overages (costs not paid for by the eye care and/or medical plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature _____Date_____

Medical History

PLEASE PRINT CLEARLY Today's Date _____
Last Name_____First Name_____M.I._____
Purpose of your visit_____

_____ _____
Date of last physical exam_____ _____
Are you allergic to ____Penicillin Sulfa___ _____Codeine_____
_____Other

Please list all medications you take (including oral contraceptives, aspirin, over-the-counter medications, vitamins and supplements) _____

List any eye surgeries_____
List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injuries: _____

_____
Are you pregnant and/or nursing? _____no _____yes
Do you wear glasses?___no_____yes If yes, how old are your present glasses?_____
Do you wear contact lenses? ____no_____yes If yes, how old are your current lenses?

_____
Type of contact lenses ____Rigid ____Soft____Extended Wear____other
Are they comfortable? _____yes _____no

Family Medical History

BROADVISION
EYE CLINIC

P O Box 30338
Metsef, Francistown
Botswana

Primary Eye Care
Contact Lenses

Tel: +267 2406540
Fax: +267 2410998
Cell: +267 74164548
Email: info@broadoptoms.com

Please list the family member(s) with the following eye or medical conditions:

Disease/Condition		**Family member (i.e. mother, paternal Grandfather, etc)**
1. Blindness	Y / N	
2. Crossed Eyes	Y / N	
3. Cataract	Y /N	
4. Glaucoma	Y / N	
5. Macular Degeneration	Y / N	
6. Retinal Disease/Detachment	Y / N	
7. Arthritis	Y / N	
8. Diabetes	Y / N	
9. Hypertension	Y / N	
10. Heart Disease	Y / N	
11. Thyroid Disease	Y / N	
12. Other		

Social History

Do you currently drive? ____yes ____no Do you have visual difficulties when Driving? ___no ___yes If yes, please describe_____
Do you use tobacco products? ____no_____yes If yes, type/amount/how long?_____

Review of Systems: Please circle. If yes, please explain.

System	**Yes or No**	**Not Sure**	**Explain/Medications**
I. Skin	**Y/ N**	**?**	
II. Neurologic			
1. Headaches/Migraine	Y/ N	?	
2. Seizures	Y/ N	?	
III. Eyes			
1. Loss of Vision	Y/ N	?	
2. Double Vision	Y / N	?	
3. "Pink"/ Red eye	Y / N	?	
4. Light Sensitive	Y / N	?	
5. Eye Pain	Y / N	?	
6. Eye Infections	Y / N	?	
7. Watery Eyes	Y / N	?	
8. Dry Eyes	Y / N	?	
IV.Ears, Nose, Mouth, Throat			
1. Allergies	Y / N	?	

BROADVISION
EYE CLINIC

P O Box 30338
Metsef, Francistown
Botswana

Primary Eye Care
Contact Lenses

Tel: +267 2406540
Fax: +267 2410998
Cell: +267 74164548
Email: info@broadoptoms.com

2. Hay Fever	Y / N	?	
3. Sinus Congestion	Y / N	?	
4. Runny Nose	Y / N	?	
5. Dry Throat/Mouth	Y / N	?	
6. Ear Infection	Y / N	?	
V. Respiratory			
1. Asthma	Y/ N	?	
2. Chronic Bronchitis	Y / N	?	
3. Emphysema	Y / N	?	
VI. Vascular			
1. Diabetes	Y / N	?	
2. High Blood Pressure	Y / N	?	
3. Vascular Disease	Y/ N	?	
VII. Gastrointestinal			
1. Diarrhea	Y / N	?	
2. Constipation	Y / N	?	
VIII. Genitourinary			
1. Genitals	Y / N	?	
2. Kidney/Bladder	Y / N	?	
IX. Bones/ Joints/ Muscles			
1. Rheumatoid Arthritis	Y / N	?	
2. Muscle/ Joint Pain	Y / N	?	
X. Lymphatic/ Hematological			
1. Anemia	Y / N	?	
2. Bleeding Problems	Y / N	?	
XI. Endocrine			
1. Thyroid/ Other	Y/ N	?	
XII. Psychiatric			
1. Anxiety/ Depression	Y / N	?	