Mr. □ Mrs. □ Ms. □ Dr. □ Date: _____

Name _____ Birth Date _____

Social Security Number _____ Driver's License Number _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone Number (_____) _____ Work Phone Number (_____) _____

Employed By: _____

Hobbies or Special Interests: _____

Spouse's Name: _____ Referred By: _____

Who is responsible for paying for services? _____

Secondary Insurance Coverage? Yes □ No □ If yes, which? _____ Flexible Spending Account? Yes □ No □

In case of emergency, whom can we contact? _____Phone Number (_____)_____

Name of Medical Doctor_____ Doctor's Phone Number (____) _____

Last Medical Exam _____/_____/_____ Last Eye Exam _____/_____/_____

Briefly state any visual problems: _____

Acknowledgement of Financial Responsibility

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for the services rendered, including reasonable attorney's fees and costs of collection in the even of default. I further understand that if payment becomes past due, delinquency charges will be added to the balance at the annual rate that is allowable by the State of California.

Signature _____ Date _____

Medical History

Do you have allergies to medications? If yes, please explain _____

_____

List any medications you currently take (include oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: Crossed eyes, lazy eye, dropping lid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

_____

Are you pregnant or nursing? _____

Do you wear glasses? No □ Yes □ If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No □ Yes □ If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid □ Soft □ Extended Wear □ Other □

Are they comfortable? No □ Yes □

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions.

Disease/Condition	N	Y	?	Relationship	Disease/Condition	N	Y	?	Relationship
Cataract	☐	☐	☐	_____	Diabetes	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____	Heart Disease	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____	High Blood Pressure	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____	Kidney Disease	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____	Lupus	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____	Thyroid Disease	☐	☐	☐	_____
Cancer	☐	☐	☐	_____	Other	☐	☐	☐	_____

Review of Systems

Do you currently, or have you ever had any problems in the following areas? (If yes, please explain and list medications)

	N	Y	?	Explain/List Med		N	Y	?	Explain/List Med
Constitutional					Sinus Congestion	☐	☐	☐	_____
(fever, weight loss/gain)	☐	☐	☐	_____	Runny Nose	☐	☐	☐	_____
Integumentary (skin)	☐	☐	☐	_____	Post-Nasal Drip	☐	☐	☐	_____
Neurological					Chronic Cough	☐	☐	☐	_____
Headaches	☐	☐	☐	_____	Dry Throat/Mouth	☐	☐	☐	_____
Migraines	☐	☐	☐	_____	Respiratory				
Seizures	☐	☐	☐	_____	Asthma	☐	☐	☐	_____
Eyes					Chronic Bronchitis	☐	☐	☐	_____
Loss of Vision	☐	☐	☐	_____	Emphysema	☐	☐	☐	_____
Blurred Vision	☐	☐	☐	_____	Vascular/Cardiovascular				
Distorted Vision/Halos	☐	☐	☐	_____	Diabetes	☐	☐	☐	_____
Loss of Side Vision	☐	☐	☐	_____	Heart Blood Pressure	☐	☐	☐	_____
Double Vision	☐	☐	☐	_____	Vascular Disease	☐	☐	☐	_____
Dryness	☐	☐	☐	_____	Gastrointestinal				
Mucous Discharge	☐	☐	☐	_____	Diarrhea	☐	☐	☐	_____
Redness	☐	☐	☐	_____	Constipation	☐	☐	☐	_____
Sandy/Gritty Feeling	☐	☐	☐	_____	Genitourinary				
Itching	☐	☐	☐	_____	(genitals/kidney/bladder)	☐	☐	☐	_____
Burning	☐	☐	☐	_____	Bones/Joints/Muscles				
Foreign Body Sensation	☐	☐	☐	_____	Rheumatoid Arthritis	☐	☐	☐	_____
Excess Tearing/Watering	☐	☐	☐	_____	Muscle Pain	☐	☐	☐	_____
Glare/Light Sensitivity	☐	☐	☐	_____	Joint Pain	☐	☐	☐	_____
Eye Pain or Soreness	☐	☐	☐	_____	Lymphatic/Hematologic				
Chronic Infection of Eye/Lid	☐	☐	☐	_____	Anemia	☐	☐	☐	_____
Sties or Chalazion	☐	☐	☐	_____	Bleeding Problems	☐	☐	☐	_____
Flash/Floaters in Vision	☐	☐	☐	_____	Endocrine (thyroid)	☐	☐	☐	_____
Tired Eyes	☐	☐	☐	_____	Allergic/Immunologic	☐	☐	☐	_____
Ears, Nose, Mouth, Throat					Psychiatric	☐	☐	☐	_____
Allergies/Hay Fever	☐	☐	☐	_____					

Social History

Do you drive? No ☐ Yes ☐ If yes, do you have any difficulty when driving? No ☐ Yes ☐ If yes, please describe: _____

_____

Do you use tobacco products? No ☐ Yes ☐ If yes, type/amount/how long: _____

Do you drink alcohol? No ☐ Yes ☐ If yes, type/amount/how long: _____

Do you use illegal drugs? No ☐ Yes ☐ If yes, type, amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None ☐

_____ _____

Doctor's Signature Date