Pacific Eye Care Optometry

"You will see the difference"

Today's Date:_____

Welcome to our office. Please fill out the following questionnaire. Your responses will be treated as confidential medical information.

Name (Last, First): _____

Middle Init. _____Nickname: _____

DOB: (MM/DD/YY): _____Age: _____

Home address: _____

City _____ State _____ Zip _____

Occupation_____

Employer: _____

Hobbies: _____

Last 4 digits of SSN: _ _ _ _

Email address: _____

Home phone: (___)_____

Work phone: (___)_____

Cell phone: (___)_____

How do you prefer to be contacted?
Home phone □ Work phone □ Cell □ Email □
How did you learn about our office?

_____

Vision benefits (circle):
None VSP MES Medicare
Other (specify) _____

If you are not the insured party, please write the name, date of birth, and last 4 digits of the SSN of the person who is, and your relationship to him/her:
Name of insured: _____

Insured's Date of Birth: _____

Last 4 digits of SSN:_ _ _ _ Patient's relationship to insured: spouse/partner □ child □ other dep

Health (regular medical) insurance co:
_____ PPO □ HMO □

Name of insured: _____
ID #: _____

Person to notify in case of emergency:
Name_____

Phone number: (___)_____

Relationship to patient: _____

Eye and Medical History

What is the reason (or reasons) for your visit here today?

_____

_____

_____

Last Eye Exam (Date, Doctor):

Do you currently wear glasses? Yes/No
If yes, circle all that apply:

All the time **Reading** **Computer**

Driving **Distance** **Sunglasses**

Safety glasses **Other**

Do you have more than one pair of current prescription eyewear? Yes/No

Would you like to have thinner, lighter eyewear? Yes/No

Are there times you would rather not wear glasses? Yes/No

When did you first start wearing glasses?
Age ____ I do not wear glasses _____

Do you use a computer? Yes/No
If yes, how many hours (average) per day? ___

Do you have sunglasses that filter 100% UVA/UVB rays? Yes/No/Unknown

Are you bothered by glare or reflection, particularly when night driving? Yes/No

Do you wear contact lenses? Yes/No

If no, are you interested in a free contact lens "test drive?" Yes/No

If yes, which type do you wear?
Soft RGP Other

Lens Brand/Powers (if known):

Average hours worn/day: _____

Cleaning/disinfection solution(s):

How often do you sleep in your lenses?

At what age did you first start wearing contacts?

(Please turn over)

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Do you experience any of the following eye symptoms? (Circle all that apply)

Burning Itching Tearing/watering Irritation Foreign body sensation

Eyestrain Headaches Pain Sunlight sensitivity Glare Sensitivity

Floaters Light flashes Blurry vision Double vision

Have you ever had any eye injuries or surgeries to your eyes? If yes, please list the injury or surgery, and indicate which eye(s) and the approximate date(s). No Yes:

_____

_____

Have you or has a family member been diagnosed with or treated for any of the following?

	Self	Family (indicate who)
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Cataracts		
Strabismus (eye turn)		
Ambylopia		
Other eye condition(s)		
Diabetes		
High blood pressure		
Thyroid condition		
High cholesterol		
Cancer		
Heart disease		

Are you being followed by a doctor for any medical condition(s)? Yes/No If yes, please list:

_____

_____

_____

When was your last physical exam with your primary care provider or internist?

_____

Who is your primary care provider or internist? (name and city)

_____

_____

Do you have any <u>allergies to medications</u>? Yes/No If yes, please list:

_____

_____

Have you ever had an allergic reaction to drops used in an eye exam? Yes/No

Do you have seasonal allergies/hay fever? Yes/No

Do you have latex allergy? Yes/No

Do you have any other allergies? Yes/No
If yes, please list here:

_____

_____

Are you using any medications or drops <u>for your eyes</u>, either prescription or over the counter? Yes/No
If yes, please list here:

Are you using <u>any other medications</u>, both prescription and over the counter? Yes/No
If yes, please list here:

Do you smoke? Yes/No
Do you drink alcohol? Yes/No

I understand that I am responsible for any fees not covered by my insurance:

Print name: _____

Signature: _____

Relationship to patient: _____