

WELCOME TO SAN RAMON FAMILY OPTOMETRY

This questionnaire is part of your confidential record. Please be as accurate as possible.

Have you been seen at our office before? [] Y [] N If yes, approximate date: _____

Patient Name: _____ DOB _____ Age: _____ E-mail Address: _____

Home Address: _____ City: _____ Zip: _____

Primary Number:() _____ - _____ Secondary Number:() _____ - _____ Tertiary Number:() _____ - _____

Do you work at a computer?: [] Y [] N. If yes, how many hours each day _____ Social Security Number _____

VERY IMPORTANT! NEW PATIENTS, WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Name if friend or relative: _____ [] Other Dr. _____ [] Walk in [] Ins. Co.

Vision Insurance Provider: [] VSP [] Eyemed [] MES [] Superior [] Other _____

Primary Member's Information: Name _____ Birthdate _____ Last 4 of SS Number _____

Date of last Eye examination:		Location of last Eye Examination:	
Do you wear glasses?	[] Y [] N	Age of glasses:	
Do you wear Contacts?	[] Y [] N	Age of Contacts:	
Any allergies to medications?	[] Y [] N	Which medications:	
Have you had any head or eye injuries?	[] Y [] N	Please explain:	
Have you had any head or eye surgeries?	[] Y [] N	Please Explain:	
Are you interested in Lasik	[] Y [] N	Any questions:	
Current Medications:			
Social History: This information is kept strictly confidential [] I would like to discuss my history with my doctor (check box)			
Do you drive?	[] Y [] N	State any difficulties:	
Do you use tobacco?	[] Y [] N	Type/Amount/How long:	
Do you use alcohol?	[] Y [] N	Type/Amount/How long:	
Do you use narcotics?	[] Y [] N	Type/Amount/How long:	
Do you have any history of being affected with:	[] Gonorrhea [] Hepatitis [] HIV [] Syphilis [] Herpes		

Medical History: Please indicate if you or any family members, living or deceased have had any of the following conditions:

- Crossed Eyes: [] Self [] Mother [] Father [] Other Relative _____
- Lazy Eye: [] Self [] Mother [] Father [] Other Relative _____
- High Blood Pressure: [] Self [] Mother [] Father [] Other Relative _____
- Glaucoma: [] Self [] Mother [] Father [] Other Relative _____
- Retinal Disease: [] Self [] Mother [] Father [] Other Relative _____
- Cataracts: [] Self [] Mother [] Father [] Other Relative _____
- Diabetes: [] Self [] Mother [] Father [] Other Relative _____
- Eye Disease: [] Self [] Mother [] Father [] Other Relative _____
- Blindness: [] Self [] Mother [] Father [] Other Relative _____
- Macular Degeneration: [] Self [] Mother [] Father [] Other Relative _____
- Arthritis: [] Self [] Mother [] Father [] Other Relative _____
- Cancer: [] Self [] Mother [] Father [] Other Relative _____

Review of Symptoms: check the box if you have recently had any problems in the following areas:

- | | | |
|-------------------------------------|---|---------------------------------|
| Headaches [] Y [] N | Itching [] Y [] N | Allergies/Hayfever [] Y [] N |
| Migraines [] Y [] N | Burning [] Y [] N | Sinus Congestion [] Y [] N |
| Seizures [] Y [] N | Foreign body Sensation [] Y [] N | Runny nose [] Y [] N |
| Loss of Vision [] Y [] N | Excess Tearing/Watering [] Y [] N | Post-Nasal Drip [] Y [] N |
| Blurred Vision [] Y [] N | Glare/Light Sensitivity [] Y [] N | Chronic Cough [] Y [] N |
| Disturbed Vision/Halos [] Y [] N | Eye Pain or Soreness [] Y [] N | Dry Throat/Mouth [] Y [] N |
| Loss of side Vision [] Y [] N | Chronic Infection of Eye or Lid [] Y [] N | Asthma [] Y [] N |
| Double Vision [] Y [] N | Styes or Chalazian [] Y [] N | Chronic Bronchitis [] Y [] N |
| Dryness [] Y [] N | Flashes/Floaters in Vision [] Y [] N | Emphysema [] Y [] N |
| Mucous Discharge [] Y [] N | Tired Eyes [] Y [] N | Diabetes [] Y [] N |
| Redness [] Y [] N | Fever/Weight Loss/Gain [] Y [] N | Heart Pain [] Y [] N |
| Sandy or Gritty Feeling [] Y [] N | Endocrine [] Y [] N | High Blood Pressure [] Y [] N |
| Vascular Disease [] Y [] N | Genitals/Kidney/Bladder [] Y [] N | Joint Pain [] Y [] N |
| Diarrhea [] Y [] N | Rheumatoid Arthritis [] Y [] N | Bleeding Problems [] Y [] N |
| Constipation [] Y [] N | Muscle Pain [] Y [] N | Psychiatric [] Y [] N |
| Anemia [] Y [] N | | |

Payment Terms: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service.
I have read and agree to all provisions of the office policy

Patient's/Parent's/Guardian's Signature

Date