Patient Medical History:

List current medication's (include eye medication's):

_____

_____

_____

Last Eye Exam_____

Medical Doctor_____

Medical Doctor Phone_____

Last Medical Exam_____

Any know eye diseases_____

Eye injuries or surgeries_____

Any known allergies_____

Family Medical History:

	Relationship
___ Blindness	_____
___ Cataracts	_____
___ Crossed Eyes	_____
___ Glaucoma	_____
___ Macular Degeneration	_____
___ Retinal Detachment	_____
___ Arthritis	_____
___ Cancer	_____
___ Diabetes	_____
___ Heart Disease	_____
___ High Blood Pressure	_____
___ Lupus	_____
___ Kidney Disease	_____
___ Thyroid Disease	_____
___ Other	_____

Do you currently have or previously had any of the following:

	No	Yes
Constitutional		
Fever/weight Loss/Gain	___	___
Cardiovascular		
Diabetes	___	___
High Blood Pressure	___	___
Ear, Nose, Mouth, Throat		
Allergies/Hay Fever	___	___
Sinus Congestion	___	___
Respiratory		
Asthma	___	___
Gastrointestinal		
Diarrhea	___	___
Constipation	___	___
Genitourinary	No	Yes
Genitals/Kidney/Bladder	___	___
Musculoskeletal		
Arthritis	___	___
Integumentary		
Skin Conditions	___	___
Neurological		
Headaches	___	___
Migraines	___	___
Seizures	___	___
Psychiatric	___	___
Endocrine		
Thyroid/Other Glands	___	___
Hematologic/Lymphatic		
Anemia	___	___
Bleeding Problem	___	___
Allergic/Immunologic	___	___
Eyes		
Loss of Vision	___	___
Distorted Vision	___	___
Loss of Side Vision	___	___
Itching/Burning	___	___
Foreign Body Sensation	___	___
Excess Tearing/Watering	___	___
Light/Glare Sensitivity	___	___
Chronic Eye/Lid Infection	___	___
Sties/Chalazion	___	___
Flashes/Floaters in Vision	___	___

*If you use eye drops, what type?*_____

Do your eyes feel dry, sore or painful?

___Never ___Sometimes ___Often ___Always

Do you experience periods of blurred vision?

___Never ___Sometimes ___Often ___Always

How often do your eyes feel tired?

___Never ___Sometimes ___Often ___Always

Do you have any problems with your eyes when on a computer, watching tv or reading?

___Never ___Sometimes ___Often ___Always

_____

Payment is expected at the time services are provided. A 50% deposit is required on all materials ordered. Balances are due at the time materials are received.

I authorize payment to Valley Center Optometry for all benefits due or becoming due under my Medicare and/or group insurance policy for the services and/or materials rendered.

I authorize the release of my/my child's medical records by the staff of Valley Center Optometry on the request from my Medical provider or my Insurance provider.

_____

(Patient/Parent/Guardian Signature) (date)

Valley Center Optometry

(760)751-8771

Today's Date: _____

Patient Information

Last Name_____

First Name_____MI_____

Street_____

City_____

State_____Zip Code_____

Cell Phone_____

Home Phone_____

Work Phone_____

Sex: Male Female

Date of Birth:_____Age_____

Employer/School_____

Occupation/Grade_____

Spouse/Parent Name_____

Spouse/Parent Employer_____

Email Address_____

In case of emergency:

_____

(name) (phone) (relation)

What is the primary purpose for this visit?

_____

Any problems with current contacts or glasses?

_____

Lifestyle Questions

Do you... (check if answer is yes)

____ work at a computer? _____ hrs per day
____ have an interest in trying contact lenses?
____ participate in sports? Type _____
____ have prescription sunglasses?
____ have more than one pair of glasses?
____ have an interest in Laser Vision Correction?

Very Important!

Whom may we thank for referring you to our office?
Name _____

If not referred, how did you choose our office?

____ Insurance Company
____ Saw sign/building
____ Yellow Pages
____ Web Search
____ Other_____

Insurance Information

Vision Insurance_____

Subscriber Name_____

Subscriber ID #_____

Subscriber Birthdate_____

Medical Insurance_____

Subscriber Name_____

Subscriber ID #_____

Subscriber Birthdate_____

I understand that I am responsible for any charges not covered by my vision or medical insurance.

_____

(Signature) (Date)

TURN OVER-----→