WELCOME TO FAMILY OPTOMETRY OF SILICON VALLEY

Record No. (Office Use)_____

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This information is held in strict confidence and will not be shared outside of this office without informed consent.

PLEASE PRINT

Name: _____ Male:❒ Female:❒ Date:___/___/_____
First Name MI Last

Check which phone no. is best to contact you ❒

Address:_____ ❒ Home Ph:( )_____

_____ _____ _____ ❒ Work Ph:( )_____
City State Zip

Birth Date: ____/____/____ SSN: _____ ❒ Cell Ph:( )_____

Occupation:_____ Employer: _____

Spouse or Parent/Guardian's Name:_____ E-mail:_____

Marital Status: ❒Married ❒Single ❒Separated ❒Divorced ❒Widowed

Children: _____ ____ _____ ____ _____ ____ _____ ____
Name Age Name Age Name Age Name Age

Who referred you to us?_____ ❒Insurance List: ❒Yellow Pages: Other:_____

Name of Medical Doctor:_____ Dr's Phone: ( )_____

Name of Previous Eye Doctor:_____ Last Eye Exam: ____/____/____

Responsible Party: Name: _____Relation to Patient:_____

Address:(If different from above):_____ Home Ph: ( )_____

City: _____ State: _____ Zip:_____ Work Ph: ( )_____

Vision Insurance: Name of Insured: _____Relation to Patient:_____

❒VSP ❒Medicare ❒MES ❒Eyemed ❒Other_____ SSN/Member ID: _____

Insured Birthdate: ____/____/____ Insured's Employer:_____ W Ph: ( )_____

Medical Insurance: Name of Insured: _____Relation to Patient:_____

❒PPO ❒HMO ❒Medicare ❒Blue Cross ❒Other _____ ❒Supplemental_____

SSN/Member ID: _____Group Name: _____ Group No. _____

Patient Medical Questionnaire

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas?:

Eyes
- ❒Blurred Vision
- ❒Loss of Vision
- ❒Double Vision
- ❒Dry Eyes
- ❒Mucous discharge
- ❒Redness
- ❒Itching/burning
- ❒Eye Swelling
- ❒Tired Eyes
- ❒Excess Tearing
- ❒Eye Pain/Soreness
- ❒Glare/Light Sensitivity
- ❒Eye or Lid Infection
- ❒Stye
- ❒Glaucoma
- ❒Flashes/Floaters

Ears, Nose, Mouth, Throat
- ❒Allergies/Hay Fever
- ❒Sinusitis
- ❒Dry Throat/Mouth

Respiratory
- ❒Asthma
- ❒Chronic Bronchitis
- ❒Emphysema
- ❒COPD

/ _____

- ❒Diabetes

Endocrine
- ❒Thyroid/Other Glands
- ❒Heart Disease
- ❒High Blood Pressure
- ❒Vascular Disease/ _____

Constitutional
- ❒Recent Weight Loss/Gain

Neurological
- ❒Headache
- ❒Migraines
- ❒Seizures
- ❒Multiple Sclerosis

Bones/Joints/Muscles
- ❒Muscle/Joint Pain
- ❒Rheumatoid Arthritis

Psychiatric/Emotional/Affect
- ❒Depression
- ❒Anxiety

Allergic/Immunologic
- ❒Lupus
- ❒Atopy
- ❒HIV/AIDS

Other:_____

Please Turn This Form Over and Complete Side Two

Eye Surgeries [e.g.LASIK , Cataract Surgery, include which eye(s) and Date(s)]_____

_____

Please list all medications (include Oral contraceptives, Aspirin, Over-The-Counter, and Homeopathic Meds)

_____

_____

Do you have any allergies to medications? ❒No ❒Yes If Yes, explain:_____

_____

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

_____

Are you Pregnant and/or Nursing? ❒No ❒Yes

YOUR VISION REQUIREMENTS:

Do you wear eyeglasses? ❒No ❒Yes If so, for what purpose? (check all that apply)

❒At all times ❒Distance Vision ❒Near/reading Vision ❒Sun Protection

❒Sports ❒Safety/Work ❒Computer ❒Other:_____

Hobbies/Recreation/Sports:_____

Do you wear **contact lenses**? ❒No ❒ Yes Are you interested in contact lenses? ❒No ❒ Yes

If yes, describe your vision with the lenses: ❒Fine: ❒Adequate: ❒ Poor: Are they comfortable? ❒ No ❒Yes

What type of **contact lenses** do you wear?

❒Soft ❒Rigid Gas Permeable ❒Bifocal ❒Monovision

❒Extended Wear ❒Disposable ❒Astigmatic (Toric) ❒1-Day

Do you work at a computer terminal? ❒No ❒Yes If so, how many hours per day?_____

On what **new developments in vision care** would you like more information?

❒Computer Vision Syndrome ❒Thinner, lighter spectacle lenses ❒Healthier Contact Lenses

❒Corneal Refractive Therapy (Nonsurgical correction of vision) ❒Laser Vision Correction

SOCIAL HISTORY:

Do you drive? ❒No ❒Yes Describe any vision problems while driving:_____

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/recreational drugs? ❒No ❒Yes type/amt/how long:_____

_____

FAMILY HISTORY:

Please note history (parents, grandparents, siblings, children; living or deceased):

DISEASE/CONDITION	RELATIONSHIP TO YOU	DISEASE/CONDITION	RELATIONSHIP TO YOU
❒Blindness		❒Arthritis	
❒Cataract		❒Cancer	
❒Crossed Eyes		❒Diabetes	
❒Glaucoma		❒Heart Disease	
❒Macular Degeneration		❒High Blood Pressure	
❒Retinal Detachment		Other:_____	
Other:_____		Other:_____	

_____ _____ _____ _____

Patient Signature Date Doctor's Signature Date

Addendums to the Above Findings:

Date:	Addendums/Changes (Please note any changes to above at future visits)	
___/___/___	_____	Initial _____
___/___/___	_____	Initial _____
___/___/___	_____	Initial _____
___/___/___	_____	Initial _____
___/___/___	_____	Initial _____