

San Leandro Optometry Group

510 483-4770

PATIENT INFORMATION

Check One: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Minor	Today's Date: _____
Name: _____	Email address: _____
Address: _____	Social Security #: _____
_____	Date of Birth: _____
Home Phone: _____	Is Responsible Party the patient? <input type="checkbox"/> Yes
Last Eye Exam _____	<input type="checkbox"/> No Name: _____ Relation: _____
Last Prescription _____	

EMPLOYMENT INFORMATION

Employer: _____	Occupation: _____
Work Address: _____	Work Phone: _____
_____	Cell Phone: _____

REFERRAL INFORMATION

How did you find out about us? <input type="checkbox"/> Insurance list <input type="checkbox"/> Walked by <input type="checkbox"/> Internet
<input type="checkbox"/> Doctor _____ <input type="checkbox"/> Existing patient _____ <input type="checkbox"/> Other _____

INSURANCE INFORMATION

Name of Vision Insurance: <input type="checkbox"/> VSP <input type="checkbox"/> MES <input type="checkbox"/> Eyemed <input type="checkbox"/> Medi-care <input type="checkbox"/> Spectera <input type="checkbox"/> None <input type="checkbox"/> Other _____
Name of Primary Medical Insurance: _____
Group No. _____ Member Name: _____

MEDICAL HISTORY

1. Do you have any allergies to medications? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, explain: _____ _____															
2. List any medication you take (include oral contraceptives, aspirin, over the counter and home remedies): _____ _____ _____															
3. List all major injuries, surgeries and/or hospitalizations you have had: _____ _____															
4. Have you ever been told you had any of the following? (Mark where appropriate)															
<table><tr><td><input type="checkbox"/> crossed eyes</td><td><input type="checkbox"/> lazy eye</td><td><input type="checkbox"/> drooping eyelid</td></tr><tr><td><input type="checkbox"/> prominent eyes</td><td><input type="checkbox"/> glaucoma</td><td><input type="checkbox"/> retinal disease</td></tr><tr><td><input type="checkbox"/> cataracts</td><td><input type="checkbox"/> eye infections</td><td><input type="checkbox"/> eye injuries</td></tr><tr><td><input type="checkbox"/> macular degeneration</td><td><input type="checkbox"/> diabetes</td><td><input type="checkbox"/> hypertension</td></tr><tr><td><input type="checkbox"/> stroke</td><td><input type="checkbox"/> heart problems</td><td><input type="checkbox"/> _____</td></tr></table>	<input type="checkbox"/> crossed eyes	<input type="checkbox"/> lazy eye	<input type="checkbox"/> drooping eyelid	<input type="checkbox"/> prominent eyes	<input type="checkbox"/> glaucoma	<input type="checkbox"/> retinal disease	<input type="checkbox"/> cataracts	<input type="checkbox"/> eye infections	<input type="checkbox"/> eye injuries	<input type="checkbox"/> macular degeneration	<input type="checkbox"/> diabetes	<input type="checkbox"/> hypertension	<input type="checkbox"/> stroke	<input type="checkbox"/> heart problems	<input type="checkbox"/> _____
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<input type="checkbox"/> stroke	<input type="checkbox"/> heart problems	<input type="checkbox"/> _____													
5. Are you pregnant or nursing? <input type="checkbox"/> No <input type="checkbox"/> Yes															
6. Do you wear glasses? <input type="checkbox"/> No <input type="checkbox"/> Yes if yes how old is your present pair? _____															
7. Do you wear contact lenses? <input type="checkbox"/> No <input type="checkbox"/> Yes if yes how old is your present pair? _____															
8. What type of contact lenses? <input type="checkbox"/> Rigid <input type="checkbox"/> Soft <input type="checkbox"/> Extended wear <input type="checkbox"/> Other _____															
9. Are they comfortable? <input type="checkbox"/> No <input type="checkbox"/> Yes															

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

YES, I would prefer to discuss my Social History information directly with my doctor.

1. Do you drive? No Yes If yes, do you have visual difficulty when driving?
 No Yes If yes, describe: _____

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

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

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

5. Have you ever been exposed to or infected with: Gonorrhea hepatitis HIV Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEMS	NO	YES	?	SYSTEM	NO	YES	?
Constitutional				Ears, Nose, Mouth, Throat			
Fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Respiratory			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/cardiovascular			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/kidney/bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/joints/muscles			
Eye pain/soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sty/chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphaatic/hematologic			
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/other gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

I understand that if my insurance cannot provide prior guarantee of payment, I will be responsible for all charges incurred at the time of service. I hereby authorize San Leandro Optometry Group to release information applicable to benefits payable for services.

Signature: _____

Date: _____