MILL VALLEY OPTOMETRY

61 Camino Alto, Suite 100A, Mill Valley, CA 94941
415.381.2020

Date____________________ E-mail ____

Name ____________________________________ Date of birth ______________ Age _____ Sex M ☐ F ☐

Address__________________________________ City________________________ State______ Zip_______

Responsible Party: ______________________________ SS #____________________________________

Telephones: Home #________________________ Wk. # ______________________ Cell # ________________________

Employer/School: ______________________________ Occupation/Grade: ______________________________

Vision insurance: VSP ☐ Eye Med ☐ Other ______________________________________

Subscriber Name ____________________________ SS #____________________ DOB____________________

Medical Insurance: ____

Subscriber Name ____________________________ SS #____________________ DOB____________________

Please list other people living in your home:

Name_________________ Relationship________ Age _____ Name_________________ Relationship________ Age _____

Name_________________ Relationship________ Age _____ Name_________________ Relationship________ Age _____

Date of last eye exam: ______________________________ Name of Doctor: ______________________________

Do you wear glasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No Brand _________________ How many years?____

What is the reason for today's visit? Who referred you? ______________________________

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EYE HEALTH HISTORY

Do you experience any of the following? Please check if YES.

☐ Blurry vision ☐ Redness ☐ Light sensitivity ☐ Double vision ☐ Dryness
☐ Flashes/floaters ☐ Eye pain ☐ Headaches/migraines ☐ Squinting ☐ Tired/Achy Eye
☐ Burning/itching ☐ Dizziness/Balance ☐ Other ______________________________

MEDICAL HISTORY

Date of last medical exam: ____________________ Doctor's name: ______________________________________

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List all medications you are currently taking and why *(Use other side if necessary)*

Medication__________________________________ Dose__________ Reason__________________________________

Medication__________________________________ Dose__________ Reason__________________________________

Medication__________________________________ Dose__________ Reason__________________________________

Have you or a member of your family had a history of the following?

	SELF	*Family member (list)*			*SELF*	*Family member (list)*	
Sinus, ears, nose	☐	☐	__________	Neurologic (seizures)	☐	☐	__________
Bones, joints, arthritis	☐	☐	__________	Strabismus/Amblyopia	☐	☐	__________
Respiratory (lungs, breath)	☐	☐	__________	Thyroid Disease	☐	☐	__________
Stroke	☐	☐	__________	Chronic Fatigue	☐	☐	__________
Heart disease	☐	☐	__________	Diabetes	☐	☐	__________
Allergies	☐	☐	__________	Digestive disease	☐	☐	__________
Cataracts	☐	☐	__________	Macular Degeneration	☐	☐	__________
Glaucoma	☐	☐	__________	Retinal detachment	☐	☐	__________
Keratoconus	☐	☐	__________	Cancer	☐	☐	__________
Arthritis	☐	☐	__________	High Cholesterol	☐	☐	__________

Please list all allergies, including those to medications:

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