Welcome to Lemon Grove Optometry

Thank you for choosing our office for your eye care needs. We are pleased to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following important information. If you have any questions, please don't hesitate to ask.

Name _____ Birthdate _____/_____/_____ SSN _____

Address_____ Apt. # _____ City_____ State_____

Zip Code _____Home Phone_____ Work Phone_____

Cell Phone_____ Employer _____Occupation_____

E-Mail _____ Marital Status _____

Who may we thank for referring you to our office? ☐ Insurance ☐ Online ☐ Patient Referral ☐ Walk-in

If patient referral, please provide his/her name _____

INSURANCE INFORMATION

Please provide your medical and vision insurance card to the front desk

Vision Insurance *(please circle):* VSP MES EYEMED MEDICARE Other _____

Name of Insured _____ DOB _____/_____/_____ Insured SSN_____

Medical Insurance

Insurance Name _____ Flexible Spending Account? YES / NO

Do you wear glasses? □ Yes □ No *If yes, how old are your present pair of lenses?* _____

What is the main reason for your visit today? _____

Lifestyle Questions

What do you think is most important for us to accomplish today?

□ Be on time □ Budget friendly eyewear □ Fashionable eyewear □ Contact Lenses □ LASIK information

I spend most of my time □ Indoors □ Outdoors Are you interested in contacts? □ Yes □ No

How much time do you spend at the computer each day? □ 0-1 hr □ 1-3 hrs □ 3-5 hrs □ 5+ hrs

Do you have glare while driving at night or on the computer screen? □ Yes □ No

Do you currently have prescription sunglasses? □ Yes □ No

Do you have a backup pair of glasses? □ Yes □ No

MEDICAL HISTORY

Allergic to any medications? Yes / No If Yes, please list: _____ Reaction: _____

Please list any current medications including over the counter medications you are taking:

_____

Personal Eye Information	**Y**	**N**	**Please explain**
Blurred Vision			
Loss of Vision			
Excess Tearing/Watering			
Dryness			
Tired Eyes			
Floaters/Flashes			
Redness			
Itching			
Inflammation of the eyelid			
Eye pain/Soreness			
Eye Surgeries/Injury			
Allergies			
Headaches			
Social History	**Y**	**N**	**Frequency of use**
Cigarette/Tobacco/Smokeless Tobacco			
Alcohol Use			

Do you have problems with any of these systems?	**Y**	**N**	**Explain (include type & date of diagnosis if applicable)**
Cardiovascular (High Blood Pressure, High Cholesterol, Heart Dz)			
Endocrine (Diabetes, Thyroid, Gout, Renal Dz)			
Gastrointestinal (Ulcer, Bladder, Colon/Liver C.)			
Genitourinary (Kidney Stones, Prostate C., STD)			
Ear, Nose, Throat, Mouth (Sinus Congestion, Dry Throat/Mouth)			
Hematologic/Lymphatic (Anemia, Bleeding, Breast C.)			
Immunologic (HIV Positive, STD)			
Integumentary (Skin, Lupus)			
Musculoskeletal (Arthritis, Osteoporosis)			
Neurological (Headaches, Migraines, Seizures)			
Psychiatric (Anxiety, Depression)			
Respiratory (Asthma, Bronchitis, Emphysema)			

FAMILY HISTORY	**Y**	**N**	**Who in your family has had the following?**
Macular Degeneration			
Glaucoma			
Other Eye Conditions			

I acknowledge receipt of Lemon Grove Optometry's Notice of Privacy Practice

X _____ **Date completed**_____