Dr. Dea Dr. Osias Dr. Saavedra

PATIENT INFORMATION

Check One:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Minor

Name: ______________________

Address: ______________________

____

Home Phone: ______________________

Last Eye Exam __________

Last Prescription__________

Today's Date:______________________

Email address: ______________________

Social Security #: ______________________

Date of Birth: ______________________

Is Responsible Party the patient? ☐ Yes ☐ No

Name:______________Relation:__________

EMPLOYMENT INFORMATION

Employer: ______________________

Work Address: ______________________

____

Occupation: ______________________

Work Phone: ______________________

Cell Phone: ______________________

REFERRAL INFORMATION

How did you find out about us? ☐Insurance list ☐Walked by ☐Internet

☐Doctor__________ ☐Existing patient__________ ☐Other__________

INSURANCE INFORMATION

Name of Vision Insurance: ☐ VSP ☐ MES ☐ Eyemed ☐Medi-care ☐ Spectera ☐ None ☐ Other______

Name of Primary Medical Insurance: ______________________

Group No.______________ Member Name: ______________________

MEDICAL HISTORY

1. Do you have any allergies to medications? ☐ No ☐ 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)

☐crossed eyes	☐lazy eye	☐drooping eyelid
☐prominent eyes	☐glaucoma	☐retinal disease
☐cataracts	☐eye infections	☐eye injuries
☐macular degeneration	☐diabetes	☐hypertension
☐stroke	☐heart problems	

5. Are you pregnant or nursing? ☐No ☐Yes
6. Do you wear glasses? ☐No ☐Yes if yes how old is your present pair? __________
7. Do you wear contact lenses? ☐No ☐Yes if yes how old is your present pair? __________
8. What type of contact lenses? ☐Rigid ☐Soft ☐Extended wear ☐Other__________
9. Are they comfortable? ☐No ☐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	☐	☐	☐	Allergies/Hay fever	☐	☐	☐
Skin	☐	☐	☐	Sinus congestion	☐	☐	☐
Neurological				Runny Nose	☐	☐	☐
Headaches	☐	☐	☐	Post-Nasal Drip	☐	☐	☐
Migraines	☐	☐	☐	Chronic Cough	☐	☐	☐
Seizures	☐	☐	☐	Dry Throat	☐	☐	☐
Eyes				**Respiratory**			
Loss of Vision	☐	☐	☐	Asthma	☐	☐	☐
Blurred Vision	☐	☐	☐	Chronic bronchitis	☐	☐	☐
Distorted Vision	☐	☐	☐	Emphysema	☐	☐	☐
Loss of side vision	☐	☐	☐	**Vascular/cardiovascular**			
Double vision	☐	☐	☐	Diabetes	☐	☐	☐
Dryness	☐	☐	☐	Heart pain	☐	☐	☐
Mucous discharge	☐	☐	☐	High blood pressure	☐	☐	☐
Redness	☐	☐	☐	Vascular disease		☐	☐
☐							
Sandy or gritty feeling	☐	☐	☐	**Gastrointestinal**			
Itching	☐	☐	☐	Diarrhea	☐	☐	☐
Burning	☐	☐	☐	Constipation	☐	☐	☐
Foreign body sensation	☐	☐	☐	**Genitourinary**			
Excess tearing	☐	☐	☐	Genitals/kidney/bladder		☐	☐
☐							
Glare/light sensitivity	☐	☐	☐	**Bones/joints/muscles**			
Eye pain/soreness	☐	☐	☐	rheumatoid arthritis	☐	☐	☐
Chronic infection	☐	☐	☐	Muscle pain	☐	☐	☐
Stye/chalazion	☐	☐	☐	Joint pain	☐	☐	☐
Flashes/floaters in vision	☐	☐	☐	**Lymphatic/hematologic**			
Tired eyes	☐	☐	☐	Anemia	☐	☐	☐
Endocrine				Bleeding problems	☐	☐	☐
Thyroid/other gland	☐	☐	☐	**Allergic/immunologic**	☐	☐	☐
				Psychiatric	☐	☐	☐

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

____

____

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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 Primary Eyecare Optometrics to release information applicable to benefits payable for services.

Signature: ____________________________ **Date:** ____________________________