Today's Date_____ Patient Name:_____
First Last MI

Patient Birthdate:_____/_____/_____ if a minor, Parent's Name:_____
Month Day Year

Best phone # □ cell □ home □ work #_____

Patient Address:_____
Street City State Zip

email address (this will only be used to contact you about your eyes, and will never be shared):

_____

Sex: □ M □ F □ _____ □ Married □ Widowed □ Single □ Separated □ Divorced □ Partnered

Occupation:_____ Employer:_____

Name of Vision Insurance Plan:_____ □ None

Subscriber's:_____ _____ _____
Name Social Security # Date of Birth

Who is your primary care physician:_____ □ none
What medical insurance do you use to see this physician:_____ □ none
What is your preferred pharmacy:_____ □ Ojai □ Ventura □ _____

We can contact your Dr. to get a list of current medications, **OR** you may list them below:

□ I give you permission to contact Dr._____ in □ Ojai □ city:_____

Name of Medication	Dose	Reason for taking

Allergies: Please list any medications that you are allergic to: □ none

_____ □ anaphylactic reaction (you stop breathing) □ other_____

_____ □ anaphylactic reaction (you stop breathing) □ other_____

please turn and complete back page ➡

Please list any surgeries you have had (including chemotherapy, radiation): □ none

_____

_____

_____

Eye surgeries :_____ □ none

Name of eye surgeon/ dates if known:_____

Check if you or a family member have:

	self	which relative (if any)
high blood pressure	□	_____
diabetes	□	_____
high cholesterol	□	_____
heart disease	□	_____
cataracts	□	_____
glaucoma	□	_____
macular degeneration	□	_____

other: _____

_____

Check if you have:

□ food or environmental allergies
□ indigestion
□ headache
□ migraine
□ arthritis
□ sinus congestion
□ thyroid problems
□ recent weight loss or gain
□ shortness of breath
□ anxiety or depression
□ Hepititis □A □B □C
□ HIV / Aids
□ other:

Primary diagnosis of any current medical problems and/ or any additional information that you would like the Dr. to be aware of:

Number of dependent children: _____ Number of adult children: _____ □ Check box if pregnant or nursing

Smoking history: □ never year smoking began _____ □ year smoking ended _____ □ current smoker

How did you hear about our office?_____

Your primary reason for today's visit is: _____

Person to contact in case of emergency: Name_____

Address_____

_____

Phone_____

Relationship to you_____