

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: \_\_\_\_\_

Spouse/ Partner Name: \_\_\_\_\_ Their occupation: \_\_\_\_\_

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: \_\_\_\_\_  
 your signature: \_\_\_\_\_

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

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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	<input type="checkbox"/>	_____
diabetes	<input type="checkbox"/>	_____
high cholesterol	<input type="checkbox"/>	_____
heart disease	<input type="checkbox"/>	_____
cataracts	<input type="checkbox"/>	_____
glaucoma	<input type="checkbox"/>	_____
macular degeneration	<input type="checkbox"/>	_____
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
- Hepatitis 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

Do you drink alcohol:  no  less than 1 drink per day  1-2 per day  more than 3 drinks per day

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 \_\_\_\_\_