The information in this confidential personal history form is critical to the evaluation of your vision

Patient History Name_____ Date_____

Address_____ City_____ ZIP_____

Home Phone (_____)_____ Driver's License # _____

Employer_____ Work Phone(_____)_____ Ext. _____

Social Security # _____ / _____ / _____ Person Responsible for account _____

Insurance that covers vision care? ❑ Yes ❑ No ❑ VSP ❑ AVD ❑ MES ❑ _____

Name of carrier or group _____ identification # _____

Date of your last eye examination_____ Have you ever had vision therapy? ❑ Yes ❑ No

Have you ever worn glasses? ❑Yes ❑No Do you wear glasses now? ❑ Yes ❑No

If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer monitor ❑ sports

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This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today? _____

_____

Are there times when your vision (or present lens) isn't quite right? _____

_____

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

_____

Are you interested in vision improvement? ❑ Refractive Surgery ❑ Laser Correction ❑ Non-Surgical

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HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies	❑Self	❑ Family	Lazy eye	❑ Self	❑ Family
Respiratory disease	❑Self	❑ Family	Turned eye	❑ Self	❑ Family
Cancer	❑Self	❑ Family	Color "blind"	❑ Self	❑ Family
Diabetes	❑Self	❑ Family	Light sensitive	❑ Self	❑ Family
Drug sensitive	❑Self	❑ Family	Eyestrain	❑ Self	❑ Family
Elevated cholesterol	❑Self	❑ Family	Dry eyes	❑ Self	❑ Family
Heart problem	❑Self	❑ Family	Floaters/spots	❑ Self	❑ Family
High blood pressure	❑Self	❑ Family	Flashing lights	❑ Self	❑ Family
Thyroid	❑Self	❑ Family	Retinal detachment	❑ Self	❑ Family
Migraine or headaches	❑Self	❑ Family	Blindness	❑ Self	❑ Family
Head trauma	❑Self		Cataracts	❑ Self	❑ Family
			Glaucoma	❑ Self	❑ Family
			Eye surgery or injury	_____	

Are you currently under a physician's care? ❑No ❑ Yes Dr.'s name? _____

Are you regularly taking medications? ❑No ❑ Yes Date of last physical _____

For what conditions? 1_____ 2_____ 3_____ 4_____

How is your general health? (circle one) Excllelent Good Fair Poor

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VERY IMPORTANT! ***NEW PATIENTS:*** *WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?*

*Name of friend or relative*_____

If not referred, how did you choose our office for your visual needs? Please check the appropriate answer:

❑ Relative ❑ Another Dr. Yellow Pages: ❑ Milpitas ❑ San Jose ❑ Hayward/Fremont

❑ Friend ❑ Insurance List ❑ Saw Sign/Building ❑Other_____

Please fill in both sides of this form as completely as possible

Do you wear contact lenses at this time? ❑Yes ❑No What type? _____

Have you had problems wearing contacts? ❑Yes ❑No Describe _____

Have you been told you cannot wear them? ❑Yes ❑No Are you interested in trying contacts? ❑Yes ❑No

OCCUPATION: What kind of work do you do? _____

What activities do you do at work: ***(Circle all that apply)*** driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.

Other activities: _____

Do you use a computer on your job? . . . . ❑ **Yes** ❑ **No** # hours daily _____

Do you use a computer at home? . . . . . ❑ **Yes** ❑ **No** # hours daily _____

What lenses do you wear? . . . . . ❑ **None** ❑ **glasses** ❑ **bifocals** ❑ **contacts**

When computing, do your eyes get . . . . ❑ **red** ❑ **dry** ❑ **ache** ❑ **Sore**

Do you feel pain or discomfort in your. . . ❑ **neck** ❑ **back** ❑ **shoulder**

Do letters ever seem to "swim"? . . . . . ❑ **Yes** ❑ **No**

Does office lighting bother you? . . . . . ❑ **Yes** ❑ **No**

Do reflections and glare bother you? . . . ❑ **Yes** ❑ **No**

Is it hard to proof-read, or find errors?. . . ❑ **Yes** ❑ **No**

Do you experience any of the following discomforts at work or at home?

❑ Headaches? ❑ Letters blur as you read? ❑ Occasionally see double?

❑ Eyestrain? ❑ Eyes red or watery? ❑ Pulling sensation near eyes?

❑ Get sleepy? ❑ Lose your place often? ❑ Do you avoid certain tasks?

❑ Does it take more and more effort to see clearly as the day wears on?

❑ Do you avoid reading after work, but read on weekends? How long can you read?_____

❑ Do you "hunch" closer to your work as the day wears on?

❑ Do street signs ever seem blurred as you drive home from work?

❑ Is it ever difficult to bring print or objects to clear focus? When_____

RECREATION AND LEISURE:

In what recreational activities do you participate? (*Circle* all that apply) read racquetball tennis golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities_____

Do you wear any special or protective eyewear for your sport? ❑ **Yes** ❑ **No**

Does your vision, or do your lenses, interfere with any activity? ❑ **Yes** ❑ **No**

What are you doing to protect your eyes from ultraviolet exposure?_____

Do you currently wear glasses that have an anti-reflective coating? ❑ **Yes** ❑ **No**

Television: is viewing ever uncomfortable? Please describe your discomfort:_____

_____

Do you recline while viewing? ❑ **Yes** ❑ **No** Do your lenses work for TV? ❑**Yes** ❑ **No**

Do you often play video games? ❑ **Yes** ❑ **No** # of hours daily_____

PAYMENT TERMS: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, Visa and Mastercard. A monthly rebilling fee of $5 is added to all accounts with unpaid balances after 30 days.

I have read and agree to all the provisions of the office financial policy

Signed _____ Date _____