ALEX F. GONCALVES, O.D.
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NEW PATIENT QUESTIONNAIRE

The following information will assist the doctor in your examination.

Mr. Ms. Mrs. Dr. Miss Rev.	Last Name	First	Middle	Nickname	Date
Address					Home Phone ( )
City		State	Zip Code		Work Phone ( )
Birthdate	Age	Social Security No.		Employer	
Occupation		If student, grade and school			

Please list your children's names and ages:

Spouse's Name	Employer

If dependent, name of parent or guardian

In case of emergency, notify Relationship Phone

Referred by

Person responsible for account

Do you have vision insurance that may cover part of our services? ❑ Yes ❑ No	If yes, insurance company	Policy No.
Do you have health insurance? ❑ Yes ❑ No	If yes, insurance company	Policy No.

Financial arrangements for professional services and materials should be made at the time services are performed. Please check method of payment.

❑ Cash or Check ❑ MasterCard/Visa ❑ VSP ❑ Medicare ❑ Medi-Cal

It is the policy of this office that a minimum deposit of 50% is due upon ordering of the materials. The balance is due on delivery of the prescription. We would be happy to help you fill out any insurance forms you may have.

VISION HISTORY

Are you experiencing any vision problems? If yes, describe _____

Do your eyes bother you at ❑ work? ❑ school? ❑ home? ❑ morning? ❑ afternoon? ❑ evening?

Does your work or leisure involve computers? ..... ❑ Yes ❑ No How many hours per day? _____

When was your last eye examination? ..... Month _____ Year _____ Dr. _____

Do you wear glasses? ❑ Yes ❑ No

Have you had refractive surgery? ❑ Yes ❑ No If so, when? _____

Are you interested in refractive surgery? ❑ Yes ❑ No

Do you have visual problems with any of the following?	YES	NO
Driving	❑	❑
Night Vision	❑	❑
Chalkboard at school	❑	❑
Movies	❑	❑
Television	❑	❑
Close work or reading	❑	❑
Arm's length distance	❑	❑
Sports activities	❑	❑
Computer work	❑	❑
Music	❑	❑
Other _____		

Do your eyes:	YES	NO
Ache	❑	❑
Burn	❑	❑
Itch	❑	❑
Tire	❑	❑
Water	❑	❑
Does bright light bother you?	❑	❑
Do you have double vision?	❑	❑
Do you lose your place when reading?	❑	❑
Do you read with your finger or marker?	❑	❑
Does your vision blur immediately after reading?	❑	❑
Other _____		

CONTACT LENS HISTORY

(Please Circle)

Are you currently wearing contact lenses? Yes No

If yes, circle current type: Soft Hard Rigid Gas Permeable Disposable Bifocal

What is your current wearing schedule? _____

Daily Wear (hrs./day) _____ Extended Wear (# of days) _____

Please list the care products you use on your contacts:

Disinfecting/soaking _____ Daily cleaner _____

Have you worn contact lenses in the past? Yes No

If yes, why did you discontinue wear? (circle all that apply.)

Vision Comfort Convenience Expense Other _____

PLEASE CIRCLE ANY OF THE FOLLOWING ACTIVITIES YOU PARTICIPATE IN:

Artistic Painting	Coin Collecting	Flying	Model Building	Sailing	Stamp Collecting
Baseball	Cycling	Football	Musical Instrument	Scuba Diving	Swimming
Basketball	Dancing	Golf	Photography	Sewing/Knitting	Tennis
Bowling	Driving	Home Workshop	Racquetball	Skiing	Video Games
Cards	Electronics	Hunting	Reading	Soccer	Other
Ceramics	Fishing	Jogging			

IF YOU HAVE QUESTIONS ABOUT YOUR VISION OR ANY OF THE FOLLOWING, PLEASE CIRCLE, AND WE WILL BE GLAD TO ANSWER THEM.

CONTACT LENSES:

Rigid	Toric/Astigmatic lenses
Soft	Disposable lenses
Bifocal	Extended wear lenses
Tinted soft lenses	Other
Orthokeratology	

GLASSES:

Bifocals/Trifocals	Safety Glasses
Progressive/Invisible	VDT Glasses
Photochromatics (lenses that change)	Sports Eyewear
Sunglasses	Other

GENERAL:

Color Vision	Cataracts
Children's Vision	Glaucoma
Low Vision Aids	Visual Therapy
Floaters	Other