San Ramon Family Optometry
175 Market Place
San Ramon, CA 94583
925-275-0202

Today's Date: _____
Patient's Name:_____
Date of Birth: _____
Phone Number: _____
E-mail: _____

Patient History and Information

Main reason for visit:	
Which eye (circle): Left / Right / Both	Onset (when did it start):
Duration (how long):	Timing (how often):
Context (when do you notice it):	
Severity (circle): Mild / Mod / Severe	Relief Factors (what helps):
Circle all that apply: Blurred vision Night blur Itchiness Tearing Redness Pregnant Nursing Eye strain Tired eyes Squinting Pain Double vision Dizziness Floaters Light flashes Light sensitivity Eye injury(details):_____	
# of hours per day you spend looking at an electronic device:	

Medical and Eye History

Last Eye Exam (if not here):	Last Eye Doctor (if not here):
Last Physical Exam:	Primary Care Physician:
Height:	Weight:
Recent Surgeries (what/when/where):	
Headaches (if yes,when/how often):	
List current medications:	
Allergies to medications:	
Tobacco use (circle): Prior / Current / Never	Alcohol use (circle): Prior /Social/ Never
Special medical situations (ie for women, pregnancy):	

Contact Lenses (if applicable)

What brand & power of contact lenses do you wear	
How long per day do you wear them	How often do you replace them

For Returning Patients: Initial here if there are no changes to your health history____

Any of the following conditions?	Self	Family	Relationship
Dry Eyes	Y N	Y N	
Cataract	Y N	Y N	
Glaucoma	Y N	Y N	
Macular Degeneration	Y N	Y N	
Retinal Disease	Y N	Y N	
Blindness	Y N	Y N	
Strabismus (lazy eye)	Y N	Y N	
Diabetes (HbA1c:____& date:_____)	Y N	Y N	
High Cholesterol	Y N	Y N	
High Blood Pressure	Y N	Y N	
Heart Disease	Y N	Y N	
Cancer	Y N	Y N	
Psychiatric	Y N	Y N	
Seasonal Allergies	Y N	Y N	
Asthma	Y N	Y N	
Sleep Apnea	Y N	Y N	
Other	Y N	Y N	