Patient Information and History

☐ Mrs. ☐ Ms. ☐ Mr. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth _____/_____/_____

Last Name_______________ First Name _______________ MI_____

Address_______________ City_______________ State_______ Zip _____________

Home # (______)_______________ Work # (______)_______________ Mobile # (______)_______________ May we text you? ☐Y ☐N

Employer Name _______________ Occupation _______________

Employer Address _______________ City _______________ State ______ Zip _____________

SSN # _______________ How were you referred to our office? Please list _______________

E-MAIL - You will receive appointment reminders, order notifications, yearly recalls, eye care news, and special promotions. You may opt out at any time.

VISION INSURANCE ☐ None ☐ VSP ☐ Tall Tree ☐ MES ☐ Principal ☐ Medicare Other_______________

Relationship to patient ☐ Self (*same as above - skip to Heath History section*) ☐ Dependent ☐ Spouse

Member Name_______________ Member D.O.B _____/_____/_____ Member I.D. / SSN _______________

Member Name_______________ Member D.O.B _____/_____/_____ Member I.D. / SSN _______________

HEALTH HISTORY:	Self Y	Self N	Family History *Please note relationship to you*
Diabetes Type I	☐	☐	____________
Diabetes Type II	☐	☐	____________
High Blood Pressure	☐	☐	____________
Heart Disease	☐	☐	____________
Asthma / Lung Disease	☐	☐	____________
Thyroid Disorder	☐	☐	____________
Arthritis	☐	☐	____________
Lupus	☐	☐	____________

Other _______________

Any Allergies to medications_______________

List Medications taken (*including oral contraceptives, aspirin, over the counter meds and home remedies*) _______________

OCCULAR HISTORY:	Self Y	Self N	Family History *Please note relationship to you*
Glaucoma	☐	☐	____________
Macular Degeneration	☐	☐	____________
Cataracts	☐	☐	____________
Retinal	☐	☐	____________
Optic Nerve Disease	☐	☐	____________
Eye Injury	☐	☐	____________
Eye Infections	☐	☐	____________
Blindness	☐	☐	____________
Crossed Eyes	☐	☐	____________
Lazy Eyes	☐	☐	____________
Drooping Eyelid	☐	☐	____________

Other_______________

History of LASIK / Refractive Surgery? When?_______________

SOCIAL HISTORY: Any hobbies you enjoy?_______________

Are you pregnant and / or Nursing? € No € Yes If yes, how many weeks / months along are you?_______________

Do you drive? € No € Yes If yes, do you have visual difficulty when driving? € No € Yes (explain) _______________

Do you drink alcohol? € No € Yes How often? € Social use € 1-2 drink daily € Other _______________

Do you use tobacco product? € No € Former user € Yes How often? € Less than 1pk / day € 1-2pk / day € More than 2pk / day

Do you use recreational drugs? € No € Recreational use € Chemical dependent € Other _______________

Have you ever been exposed to or infected with ?

STD's € No € Yes _______________ Blood Transfusion € No € Yes

HIV € No € Yes _______________ Hepatitis A / B / C € No € Yes

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ADVANCED EYE CARE

PATIENT HISTORY

By: By:

Last Eye Examination ☐ Never ☐ 1-2yr ☐ 3-4yr ☐ 5+ yr ☐ Dr. Aguilar, Edgar ☐ Dr. ___________________

Last Medical Exam ☐ Never _____ / _____ / _____ Name of Medical Doctor ___________________________ Dr.'s # ___________________

Do you wear glasses? ☐ No ☐ Yes If yes, how old are your current pair of lenses? ☐ 1yr ☐ 2yr ☐ Other______________

Have your eyes been dilated before? ☐ Yes ☐ No

CHIEF COMPLAINT OR HISTORY OF PRESENT ILLNESS *Please provide us the reason for your visit and the symptoms you may be experiencing:*

Reason for your visit?

☐ Routine eye exam ☐ Contact lens exam ☐ Interested in LASIK ☐ Other ____________________

OCULAR SYMPTOMS

	Yes	No
Blurry Vision Distance	☐	☐
Blurry Vision Near	☐	☐
Computer Distance	☐	☐
Blurry Night Vision	☐	☐
Burning	☐	☐
Double Vision	☐	☐
Distortion	☐	☐
Discharge	☐	☐
Dryness (Glasses/ Contacts)	☐	☐
Eye Pain / Soreness	☐	☐

	Yes	No
Excess Tearing / Watery	☐	☐
Foreign Body Sensation	☐	☐
Frequent / Severe Headaches	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Glare / Light Sensitivity	☐	☐
Itching	☐	☐
Lid Twitching	☐	☐
Redness	☐	☐
Sudden Vision Loss	☐	☐
Tired Eyes	☐	☐

COMPUTER RELATED PROBLEMS

Do you work on a computer? ☐ No ☐ Yes How many hours? _________ Approximate distance from screen _________

Do you have any of the following symptoms when working on a computer?

	Yes	No
Tearing	☐	☐
Excess Tearing / Watery	☐	☐
Foreign Body Sensation	☐	☐

Are you currently wearing computer glasses? ☐ Yes ☐ No

How old are the current lenses? ☐ 1yr ☐ 2yr ☐ Other______________

Are they single vision? ☐ Yes ☐ No ☐ Don't Know

Are they multi-focal? ☐ Yes ☐ No ☐ Don't Know

CONTACT LENS

Do you wear contact lenses? ☐ Yes ☐ No ☐ Former wearer (reason if discontinued) ____

Last worn routinely?............... ☐ Just today………. ☐ Yesterday……….☐ Few days ago…...☐ Last week………..☐ Other____________________________

How many days a week do you wear them?...........☐ Everyday…….☐ 2-3 times / week…….☐ Only occasionally…………..☐ Other____________________

Any problems with your lenses: ☐ Blurred Vision…..☐ Foggy Vision ……….☐ Dryness…………☐ Overall Discomfort…….☐ Other____________________

Are you sleeping in your lenses? ☐ Yes ☐ No If so, how often………..☐ Every night….…...☐ 2-3 times / wk……..…..☐ Only on occasion

Type of lenses:…… ☐ Soft………………..☐ Gas Permeable (Hard)……….☐ Toric (for astigmatism)……………...☐ Bifocal……………...☐ Monovision

How often are your lenses replaced?..... ☐ Daily……..….☐ 2 Weeks ……….. ☐ Monthly……….. ☐ Every 3 mos……….☐ Non-disposable / Yearly

Do you know the brand of your current contact lenses? ☐ No ☐ Yes ____

Are you interested in color contact lenses? ☐ Yes ☐ No

I hereby authorize my doctor to furnish and disclose all facts concerning this exam to my insurance. Signature and Date is required every year.

X____ _________________________________

Signature (Patient, Parent, or Guardian) **Today's Date**