San Leandro Optometry Group

510 483-4770

PATIENT INFORMATION

Check One:
□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Minor
Name: _____
Address: _____
_____
Home Phone: _____
Last Eye Exam _____
Last Prescription_____

Today's Date:_____
Email address: _____
Social Security #: _____
Date of Birth: _____
Is Responsible Party the patient?
□ Yes
□ No Name:_____Relation:_____

EMPLOYMENT INFORMATION

Employer: _____
Work Address: _____
_____

Occupation: _____
Work Phone: _____
Cell Phone: _____

REFERRAL INFORMATION

How did you find out about us? □Insurance list □Walked by □Internet
□Doctor_____ □Existing patient_____ □Other_____

INSURANCE INFORMATION

Name of Vision Insurance: □ VSP □ MES □ Eyemed □Medi-care □ Spectera □ None □ Other_____
Name of Primary Medical Insurance: _____
Group No._____ Member Name: _____

MEDICAL HISTORY

1. Do you have any allergies to medications? □ No □ Yes. If yes, explain:

_____
_____

2. List any medication you take(include oral contraceptives, aspirin, over the counter and home remedies):

_____
_____
_____

3. List all major injuries, surgeries and/or hospitalizations you have had:

_____
_____

4. Have you ever been told you had any of the following? (Mark where appropriate)

□crossed eyes	□lazy eye	□drooping eyelid
□prominent eyes	□glaucoma	□retinal disease
□cataracts	□eye infections	□eye injuries
□macular degeneration	□diabetes	□hypertension
□stroke	□heart problems	□_____

5. Are you pregnant or nursing? □No □Yes
6. Do you wear glasses? □No □Yes if yes how old is your present pair? _____
7. Do you wear contact lenses? □No □Yes if yes how old is your present pair? _____
8. What type of contact lenses? □Rigid □Soft □Extended wear □Other_____
9. Are they comfortable? □No □Yes

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

□YES, I would prefer to discuss my Social History information directly with my doctor.

1. Do you drive? □No □Yes If yes, do you have visual difficulty when driving?
   □No □Yes If yes, describe:_____
2. Do you use tobacco products?□No □ Yes If yes, type/amount/how long: _____
3. Do you drink alcohol? □No □ Yes If yes, type/amount/how long: _____
4. Do you use illegal drugs? □ No □Yes If yes, type/amount/how long: _____
5. Have you ever been exposed to or infected with:□ Gonorrhea □ hepatitis □ HIV □ Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEMS	NO	YES	?	SYSTEM	NO	YES	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, weight loss/gain	□	□	□	Allergies/Hay fever	□	□	□
Skin	□	□	□	Sinus congestion	□	□	□
Neurological				Runny Nose	□	□	□
Headaches	□	□	□	Post-Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat	□	□	□
Eyes				**Respiratory**			
Loss of Vision	□	□	□	Asthma	□	□	□
Blurred Vision	□	□	□	Chronic bronchitis	□	□	□
Distorted Vision	□	□	□	Emphysema	□	□	□
Loss of side vision	□	□	□	**Vascular/cardiovascular**			
Double vision	□	□	□	Diabetes	□	□	□
Dryness	□	□	□	Heart pain	□	□	□
Mucous discharge	□	□	□	High blood pressure	□	□	□
Redness	□	□	□	Vascular disease	□	□	□
Sandy or gritty feeling	□	□	□	**Gastrointestinal**			
Itching	□	□	□	Diarrhea	□	□	□
Burning	□	□	□	Constipation	□	□	□
Foreign body sensation	□	□	□	**Genitourinary**			
Excess tearing	□	□	□	Genitals/kidney/bladder	□	□	□
Glare/light sensitivity	□	□	□	**Bones/joints/muscles**			
Eye pain/soreness	□	□	□	rheumatoid arthritis	□	□	□
Chronic infection	□	□	□	Muscle pain	□	□	□
Sty/chalazion	□	□	□	Joint pain	□	□	□
Flashes/floaters in vision	□	□	□	**Lymphaatic/hematologic**			
Tired eyes	□	□	□	Anemia	□	□	□
Endocrine				Bleeding problems	□	□	□
Thyroid/other gland	□	□	□	**Allergic/immunologic**	□	□	□
				Psychiatric	□	□	□

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

I understand that if my insurance cannot provide prior guarantee of payment, I will be responsible for all charges incurred at the time of service. I hereby authorize San Leandro Optometry Group to release information applicable to benefits payable for services.

Signature: _____ **Date:** _____