Petaluma Eye Care
Optometric Associates, Inc.

☐ Mrs. ☐ Ms. ☐ Male ☐ Single ☐ Married
☐ Mr. ☐ Dr. ☐ Female ☐ 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 _____

EMAIL – 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 ☐ MediCal ☐ MES ☐ Principal ☐ Medicare ☐ Other _____

Relationship to patient ☐ Self (same as above – skip to Health History section)

Member Name _____ Member D.O.B. ___/___/___ Member I.D./SS # _____

Member Name _____ Member D.O.B. ___/___/___ Member I.D./SS # _____

HEALTH HISTORY	SELF Y	SELF N	Family History *Please note relationship to you*	OCCULAR HISTORY	SELF Y	SELF N	Family History *Please note relationship to you*
Diabetes, Type I	☐	☐		Glaucoma	☐	☐	
Diabetes, Type II	☐	☐		Macular Degeneration	☐	☐	
High Blood Pressure	☐	☐		Cataracts	☐	☐	
High Cholesterol	☐	☐		Retinal	☐	☐	
Heart Disease	☐	☐		Optic Nerve Disease	☐	☐	
Asthma / Lung Disease	☐	☐		Eye Injury	☐	☐	
Thyroid Disorder	☐	☐		Eye Infections	☐	☐	
Arthritis	☐	☐		Blindness	☐	☐	
Lupus	☐	☐		Crossed Eyes	☐	☐	
Other	☐	☐		Lazy Eyes	☐	☐	
Any allergies to medication	☐	☐		Drooping Eyelid	☐	☐	
List medications taken (including oral contraceptives, aspirin, over-the-counter medications and home remedies): _____				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 drinks daily ☐ Other _____

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

Do you use recreational drugs? ☐ No ☐ Recreational Use ☐ Chemical Dependent ☐ Other _____

Have you ever been exposed to or infected with?

STDs ☐ No ☐ Yes _____ Blood Transfusion ☐ No ☐ Yes

HIV ☐ No ☐ Yes _____ Hepatitis A / B / C ☐ No ☐ Yes

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PATIENT HISTORY

By: By:

Last Eye Examination ☐ Never ☐ 1-2 yr ☐ 3-4 yrs. ☐ 5+ yrs. Doctor: _____ Doctor: _____

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? ☐ 1 yr ☐ 2 yr ☐ Other_____

Have your eyes been dilated before? ☐ Yes ☐ No

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

Reason for visit?

☐ *Routine eye exam* ☐ *Contact lens exam* ☐ *Interested in LASIK* ☐ *Other* _____

OCULAR SYMPTOMS

	Yes	No			Yes	No
Blurry Vision Distance	☐	☐		Excess Tearing/Watery	☐	☐
Blurry Vision Near	☐	☐		Foreign Body Sensation	☐	☐
Computer Distance	☐	☐		Frequent/Severe Headache	☐	☐
Blurry Night Vision	☐	☐		Flashes	☐	☐
Burning	☐	☐		Glare/Light Sensitivity	☐	☐
Double Vision	☐	☐		Itching	☐	☐
Distortion	☐	☐		Lid Twitching	☐	☐
Discharge	☐	☐		Redness	☐	☐
Dryness (Glasses/Contacts)	☐	☐		Sudden Vision Loss	☐	☐
Eye Pain/Soreness	☐	☐		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	☐	☐		Are you currently wearing computer glasses? ☐ *Yes* ☐ *No*
Excess Tearing/Watery	☐	☐		How old are the current lenses? ☐ *1 yr* ☐ *2 yr* ☐*Other*_____
Foreign Body Sensation	☐	☐		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? .....☐ Every day..... ☐ 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 _____ _____ _____

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

Reviewed By:

X _____ _____

Doctor's Signature Today's Date