

Solano EyeCare

Optometric Professionals

Welcome! Please complete this form as completely and accurately as possible to ensure the best care for your vision and ocular health. All information will be kept strictly confidential.

Name _____
LAST FIRST MIDDLE
 Social Security Number _____
 Address _____
 City & Zip _____
 Email: _____

Today's Date ____/____/____
 Date of Birth ____/____/____
 Home Phone(____) _____
 Work Phone(____) _____
 Mobile Phone (____) _____

How did you learn about our office? Insurance Internet Yellowpages Walked by Personal Referral
 Is there someone we can thank for referring you to us? _____

Vision Care Insurance: None Vision Service Plan Medicare Other _____

MEDICAL HISTORY

Physician's Name _____ Date of last exam ____/____/____
 Are you allergic to any medications? No Yes→please describe _____

List any current medications (include hormones, birth control pills, aspirin, over the counter drugs, eyedrops, vitamins, homeopathic and herbal remedies): _____

If female, are you currently pregnant or nursing? No Yes

List all major hospitalizations and surgeries: _____

DO YOU OR YOUR IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING:

CONDITION	YOU	FAMILY	AFFECTED RELATIVE(S)
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Thyroid disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Arthritis/ Lupus	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Asthma/ Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Migraine Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Immune Deficiency Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cancer _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Do you drive? No Yes→Does your vision interfere with driving? No Yes
 How much alcohol do you drink per week? None 1-10drinks 11-20drinks >20 drinks
 Do you use tobacco? No Yes→ Type/ amount/ # of years _____

OCULAR HISTORY

Previous Eye Doctor _____

Date of last exam ___ / ___ / ___

What is the main reason for today's visit? _____

What is your occupation? How do you use your eyes at work? _____

Do you have any special vision needs for sports, hobbies or computer use? _____

Have you ever worn eyeglasses? No Yes → For how many years? _____

Do you wear eyeglasses now? No Yes → Always Distance vision Near vision Seldom

How long have you had your present glasses? _____

Are you having any problems with them? No Yes → _____

Have you had any type of eye surgery? No Yes → _____

Are you interested in discussing LASIK or other refractive surgery with the doctor today? No Yes

IF YOU HAVE EVER WORN CONTACT LENSES, PLEASE ANSWER THE FOLLOWING:

When did you begin wearing contacts? _____ What type? _____

Do you still wear them? Yes No → Why not? _____

How old is your current pair? _____ Do you ever sleep with your lenses in? No Yes

What solutions do you use to care for your contacts? _____ Eyedrops? _____

Are you interested in discussing new advancements in contact lenses with the doctor today? No Yes

DO YOU OR YOUR IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING:

CONDITION	YOU	FAMILY	AFFECTED RELATIVE(S)
Blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cataracts	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Retinal detachment	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Macular degeneration	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Strabismus ("wandering eye")	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Amblyopia ("lazy eye")	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Ocular allergies/ hayfever	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Ocular disease or accident	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Vision therapy/ eye exercises	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?

Blurred vision at all distances	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blurred vision only at distance	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pain in/ around eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blurred vision only at near	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sensitivity to light	<input type="checkbox"/> No <input type="checkbox"/> Yes
Double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Floating black spots in vision	<input type="checkbox"/> No <input type="checkbox"/> Yes
Itching eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Flashing lights in vision	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burning eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Halos around lights	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	Temporary loss of vision	<input type="checkbox"/> No <input type="checkbox"/> Yes
Excessive tear formation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems with color vision	<input type="checkbox"/> No <input type="checkbox"/> Yes
Redness in/ around eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Eyelid infection	<input type="checkbox"/> No <input type="checkbox"/> Yes
Discharge from eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Doctor reviewed & changes noted on ___ / ___ / ___ by _____