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____ Today's Date____/____/____
LAST FIRST MIDDLE

Social Security Number ____________________________________ Date of Birth ____/____/____

Address____ Home Phone (____)____________

City & Zip____ Work Phone (____)____________

Email____ Mobile Phone (____)___________

How did you learn about our office? □Internet Website:___________________ □Insurance □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): ____

____

____

List all major hospitalizations and surgeries: ____

____

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

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

CONDITION	YOU	FAMILY	AFFECTED RELATIVE(S)
High Blood Pressure	□No □Yes	□No □Yes	____________________
Heart Disease	□No □Yes	□No □Yes	____________________
High Cholesterol	□No □Yes	□No □Yes	____________________
Diabetes	□No □Yes	□No □Yes	____________________
Thyroid Disease	□No □Yes	□No □Yes	____________________
Arthritis/ Lupus	□No □Yes	□No □Yes	____________________
Kidney Disease	□No □Yes	□No □Yes	____________________
Asthma/Emphysema	□No □Yes	□No □Yes	____________________
Migraine Headaches	□No □Yes	□No □Yes	____________________
Depression	□No □Yes	□No □Yes	____________________
Immune Deficiency Disease	□No □Yes	□No □Yes	____________________
Cancer_________________	□No □Yes	□No □Yes	____________________

Do you drive? □No □Yes

How much alcohol do you drink per week? □None □1-10 drinks □11-20 drinks □>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? ____

Do you have any special vision needs for work, 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	□No □Yes	□No □Yes	____________________________
Cataracts	□No □Yes	□No □Yes	____________________________
Retinal Detachment	□No □Yes	□No □Yes	____________________________
Macular Degeneration	□No □Yes	□No □Yes	____________________________
Glaucoma	□No □Yes	□No □Yes	____________________________
Strabismus ("wandering eye")	□No □Yes	□No □Yes	____________________________
Amblyopia ("lazy eye")	□No □Yes	□No □Yes	____________________________
Ocular allergies/ hayfever	□No □Yes	□No □Yes	____________________________
Ocular disease or accident	□No □Yes	□No □Yes	____________________________
Vision Therapy/ eye exercises	□No □Yes	□No □Yes	____________________________

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?

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

In compliance with electronic health records, the federal government now requires that we ask the following questions. You, however, are not required to answer them.

Primary Language: _____________________ □Decline to Answer

Ethnicity: □Decline to Answer □Hispanic/Latino □Not Hispanic/Latino □Unknown

Race: □ Decline to Answer □American Indian/Alaska native □ Asian □ Black or African American
□ White □Native Hawaiian/other Pacific Islander □ Other race

Doctor reviewed and changes noted on _____/_____/_____by ______________________