

The information in this confidential personal history form is critical to the evaluation of your vision

Patient History Name _____ Date _____

Address _____ City _____ ZIP _____

Home Phone (_____) _____ Driver's License # _____

Employer _____ Work Phone(_____) _____ Ext. _____

Social Security # _____ / _____ / _____ Person Responsible for account _____

Insurance that covers vision care? Yes No VSP AVD MES _____

Name of carrier or group _____ identification # _____

Date of your last eye examination _____ Have you ever had vision therapy? Yes No

Have you ever worn glasses? Yes No Do you wear glasses now? Yes No

If yes: for distance only for near only wear them full time for computer monitor sports

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today? _____

Are there times when your vision (or present lens) isn't quite right? _____

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

Are you interested in vision improvement? Refractive Surgery Laser Correction Non-Surgical

- Allergies Self Family
- Respiratory disease Self Family
- Cancer Self Family
- Diabetes Self Family
- Drug sensitive Elevated Self Family
- cholesterol Self Family
- Heart problem Self Family
- High blood pressure Self Family
- Thyroid Self Family
- Migraine or headaches Self Family
- Head trauma Self

- Lazy eye Self Family
- Turned eye Self Family
- Color "blind" Self Family
- Light sensitive Self Family
- Eyestrain Self Family
- Dry eyes Self Family
- Floaters/spots Self Family
- Flashing lights Self Family
- Retinal detachment Self Family
- Blindness Self Family
- Cataracts Self Family
- Glaucoma Self Family
- Eye surgery or injury _____

Are you currently under a physician's care? No Yes Dr.'s name? _____

Are you regularly taking medications? No Yes Date of last physical _____

For what conditions? 1 _____ 2 _____ 3 _____ 4 _____

How is your general health? (circle one) Excllelent Good Fair Poor

VERY IMPORTANT! NEW PATIENTS: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Name of friend or relative _____

If not referred, how did you choose our office for your visual needs? Please check the appropriate answer:

- Relative Another Dr. Yellow Pages: Milpitas San Jose Hayward/Fremont
- Friend Insurance List Saw Sign/Building Other _____

Please fill in both sides of this form as completely as possible

Do you wear contact lenses at this time? Yes No What type? _____
 Have you had problems wearing contacts? Yes No Describe _____

Have you been told you cannot wear them? Yes No Are you interested in trying contacts? Yes No

OCCUPATION: What kind of work do you do? _____

What activities do you do at work: *(Circle all that apply)* driving typing data entry computers program
 inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.

Other activities: _____

Do you use a computer on your job?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# hours daily _____
Do you use a computer at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# hours daily _____
What lenses do you wear?	<input type="checkbox"/> None	<input type="checkbox"/> glasses	<input type="checkbox"/> bifocals <input type="checkbox"/> contacts
When computing, do your eyes get	<input type="checkbox"/> red	<input type="checkbox"/> dry	<input type="checkbox"/> ache <input type="checkbox"/> Sore
Do you feel pain or discomfort in your. . .	<input type="checkbox"/> neck	<input type="checkbox"/> back	<input type="checkbox"/> shoulder
Do letters ever seem to "swim"?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does office lighting bother you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do reflections and glare bother you? . . .	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is it hard to proof-read, or find errors? . .	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Do you experience any of the following discomforts at work or at home?

- Headaches? Letters blur as you read? Occasionally see double?
- Eyestrain? Eyes red or watery? Pulling sensation near eyes?
- Get sleepy? Lose your place often? Do you avoid certain tasks?
- Does it take more and more effort to see clearly as the day wears on?
- Do you avoid reading after work, but read on weekends? How long can you read? _____
- Do you "hunch" closer to your work as the day wears on?
- Do street signs ever seem blurred as you drive home from work?
- Is it ever difficult to bring print or objects to clear focus? When _____

RECREATION AND LEISURE:

In what recreational activities do you participate? *(Circle all that apply)* read racquetball tennis
 golf baseball basketball swim camp sew play cards flying video games musical instrument

Other recreational activities _____

Do you wear any special or protective eyewear for your sport? Yes No

Does your vision, or do your lenses, interfere with any activity? Yes No

What are you doing to protect your eyes from ultraviolet exposure? _____

Do you currently wear glasses that have an anti-reflective coating? Yes No

Television: is viewing ever uncomfortable? Please describe your discomfort: _____

Do you recline while viewing? Yes No Do your lenses work for TV? Yes No

Do you often play video games? Yes No # of hours daily _____

PAYMENT TERMS: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, Visa and Mastercard. A monthly rebilling fee of \$5 is added to all accounts with unpaid balances after 30 days.

I have read and agree to all the provisions of the office financial policy

Signed _____ Date _____