Date: _____

Pacific Eye Care Optometry

"You will see the difference"

Welcome to our office! Please fill out the following questionnaire. Your responses will be treated as confidential information.

Name (Last, First): _____

Middle Initial: _____ Nickname: _____

DoB: (MM/DD/YY): _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Hobbies: _____

Last four digits of SSN: _____

Email: _____

Home phone: (_____) _____

Cell phone: (_____) _____

Work phone: (_____) _____

How do you prefer to be contacted? (Please circle)

Home Work Cell Email

How did you learn about our office?

_____

Vision benefits (Please circle):

None VSP Tricare Medicare

Other (Please Specify): _____

If you are not the main insured party, please complete the following:

Name of Insured: _____

Insured's Date of Birth: _____

ID or last four SSN of insured: _____

Patient's relationship to the insured:

Spouse/Partner ◯ Child ◯ Other ◯

Health/Medical Insurance: HMO ◯ PPO ◯

_____

Name of insured: _____

ID Number: _____

Emergency Contact: _____

Phone: (_____) _____

Relationship to patient: _____

Vision and Medical History

What is the reason (or reasons) for your visit today?

_____

_____

_____

Last Eye Exam (Date, Doctor): _____

_____

Do you currently wear glasses? Yes / No

If yes, please circle all that apply:

Full Time **Reading** **Computer**

Driving **Distance** **Sunglasses**

Safety Glasses **Other**

Do you have more than one pair of current prescription eyewear? Yes / No

Would you like to have thinner, lighter eyewear? Yes / No

Are there times you would rather not wear glasses? Yes / No

At what age did you begin wearing glasses? _____

Do you use a computer? Yes / No

If yes, how many hours (average) per day? _____

Do you have sunglasses that filter 100% of UVA and UVB Rays? Yes / No / Unknown

Are you bothered by glare or reflection, particularly when driving at night? Yes / No

Do you wear contact lenses? Yes / No

If no, are you interested in a free contact lens "test drive?" Yes / No

If yes, which type do you wear?

Soft ◯ RGP ◯ Other ◯

Lens Brand / Powers (If known): _____

Average hours worn per day: _____

Cleaning/disinfection solution(s): _____

How often do you sleep in your lenses? _____

At what age did you begin wearing contacts? _____

(Please turn over)

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Do you experience any of the following eye symptoms? (Please circle all that apply)

Burning **Itching** **Tearing/watering**

Irritation **Foreign body sensation** **Dryness**

Eyestrain **Headaches** **Pain**

Sunlight sensitivity **Glare sensitivity**

Floaters **Light flashes**

Blurry vision **Double vision**

Have you ever had any eye injuries or surgeries to your eyes? Yes / No

If yes, please list the injury or surgery, and indicate which eye(s) and the approximate date(s):

_____

_____

Have you or a family member been diagnosed with or treated for any of the following?

	Self	Family (Please indicate who)
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Cataracts		
Strabismus (eye turn)		
Amblyopia		
Other eye condition(s)		
Diabetes		
High blood pressure		
Thyroid condition		
High cholesterol		
Cancer		
Heart disease		

Are you being followed by a doctor for any medical conditions? Yes / No

If yes, please list: _____

_____

_____

When was your last physical exam with your primary care provider or internist? _____

Who is your primary care provider or internist? (Please list name and city):

_____

_____

Do you have any allergies to medications?

If yes, please list: Yes / No

_____

_____

Have you ever had an allergic reaction to drops used in an eye exam? Yes / No

Do you have seasonal allergies or hay fever? Yes / No

Do you have latex allergy? Yes / No

Do you have any other allergies? Yes / No

If yes, please list here:

_____

_____

Are you using any medications or drops for your eyes, either prescription or over the counter? Yes / No

If yes, please list here:

_____

_____

Are you using any other medications, either prescription or over the counter? Yes / No

If yes, please list here:

_____

_____

Do you smoke? Yes / No

Do you drink alcohol? Yes / No

I understand that I am responsible for any fees not covered by my insurance:

Print name: _____

Signature: _____

Relationship to patient: _____