SAN RAMON OPTOMETRIC GROUP

Patient History Questionnaire Date____/____/_____

Full Name: ______________________________ Birth Date ____/____/_____

Address: ______________________________ SSN ______________

______________________________ Home Phone: ______________

Email Address: ______________________________ Cell Phone: ______________

Guardian (If Minor)______________________ Marital Status (Please circle) M S D W

Occupation: ______________________ Employer ______________________

Whom may we thank for referring you? ______________________________

Primary Care Physician: ______________________ Last Medical Exam: ____________

Reason for today's exam? ______________________________

OCULAR HISTORY

Do you wear glasses? ___No ___Yes If yes, how old is your present pair of lenses? ____________

Do you wear contact lenses? ___No ___Yes If yes, what type ___Rigid ___Soft ___Toric

___Multifocal ___Monovision ___Extended Wear Do you wear them ___ Full Time ___Part Time

How frequently do you replace them? ______________________________

Have you had refractive surgery? ______ If yes, Date ____________Type______________

Have you had any other eye surgeries or injuries? **(Please specify Right or Left)**

____

Are you **currently** experiencing any of the following problems with your eyes? Check if "Yes".

Please indicate RT, LT, or Both eyes and duration of symptoms.

___Blurred Vision ___Flashes/Floaters in Vision ___Redness

___Loss of Vision ___Halos/Glare/Light Sensitivity ___Excess Tearing/Watering

___Loss of Side Vision ___Dryness ___Eye Pain or Soreness

___Double Vision ___Burning ___Infections

___Tired Eyes ___Itching ___Styes or Chalazion

___Other

____

____

Please indicate RT, LT or Both and date of diagnosis.

___Cataracts ___Retinal Detachment/Disease ___Glaucoma ___Lazy Eye

___Dry Eye ___Macular Degeneration ___Crossed Eyes ___Other

____

____

MEDICAL HISTORY

Do you **currently have or are you receiving treatment** for any of the following conditions or systems? Check if "Yes" and explain below.

___Headaches/Migraines
___Asthma/Respiratory
___High Cholesterol
___Psychiatric Condition
___Gastrointestinal
___Dry Mouth
___Thyroid Disease
___Diabetes
___Arthritis/Joint Pain
___Weight Loss/Gain
___Genitourinary
___Sinus Congestion
___Seasonal Allergies
___High Blood Pressure
___Autoimmune Disease
___Integumentary (Skin)
___Anemia
___Other

Please explain: ______________________________

____

____

List any medications you are currently taking with dosage. ______________________________

____

Are you allergic to any medications? ______________________________

Reaction? ______________________________

Have you ever been diagnosed with cancer? ___Yes ___No Date ______________

Type______________ Treatment ______________

List all surgeries or hospitalizations you have had and give date: ______________________________

____

____

Are you pregnant or nursing? ______________________________

FAMILY HISTORY

Please check the appropriate boxes.

	MOTHER	FATHER	SISTER	BROTHER	AUNT	UNCLE	SON	DAUGHTER	GRANDPARENT
GLAUCOMA									
CATARACT									
MACULAR DEGENERATION									
RETINAL DISEASE									
DIABETES									
THYROID DISEASE									
LUPUS									
CANCER									
HEART DISEASE									
HIGH BLOOD PRESSURE									
KIDNEY DISEASE									
OTHER									

SOCIAL HISTORY **Do you use tobacco products? ___Yes Type/Amount/How Long______________**

___ Past Smoker **___ Never Smoked**