VALENCIA OPTOMETRY

Patient Information

Mr/Ms/Mrs.: _____MI_____ Date of Birth: _____ Age: _____

Address: _____Apt_____ Phone: (_____)_____ *home, cell or work?*

City: _____ Zip: _____ Phone: (_____)_____ *home, cell or work?*

Occupation: _____ Email Address: _____

Employer/School: _____ Emergency Contact: _____

Referred by: _____ Emergency Phone:(_____)_____

Do you have vision insurance? ☐ Yes ☐ No Insurance company: _____

Are you interested in contact lenses? ☐ Yes ☐ No Women: Are you pregnant or nursing? ☐ Yes ☐ No

Are you interested in laser eye surgery? ☐ Yes ☐ No Year of last eye exam: _____ physical exam: _____

List allergies to medication: ☐ None _____

List medications that you take (including eye drops): ☐ None _____

List major injuries, surgeries and hospitalizations: ☐ None _____

Do **you** or your **immediate family** (parents, grandparents, brothers, sisters, or children) have any of the following?

	You	*Family*		*You*	*Family*
Blindness/Loss of Vision	☐	☐	Diabetes	☐	☐
Glaucoma	☐	☐	High Blood Pressure	☐	☐
Macular Degeneration	☐	☐	Heart Disease	☐	☐
Eye Turn	☐	☐	Cancer	☐	☐

Do **you** have any of the following problems?

Eyes: (with your eyeglasses/contacts, if any)		**Constitutional:**		**Respiratory:**	
Blurred Vision	☐	Fever	☐	Asthma	☐
Loss of Vision	☐	**Skin:**		Bronchitis	☐
Double Vision	☐	Rosacea	☐	Emphysema	☐
Lazy Eye	☐	**Neurological:**		**Cardiovascular:**	
Dryness	☐	Headaches	☐	High Cholesterol	☐
Itching	☐	Seizures	☐	**Gastrointestinal:**	
Redness	☐	**Ears/Nose/Throat:**		Chronic Diarrhea	☐
Discharge	☐	Allergies/Hay Fever	☐	**Bones/Muscles/Joints:**	
Eye Pain	☐	Dry Mouth	☐	Rheumatoid Arthritis	☐
Floaters	☐	**Endocrine:**		**Lymphatic/Hematologic:**	
Flashes of Lights	☐	Thyroid Problems	☐	Bleeding Problems	☐

Other medical problems: _____

Social History: (*Please discuss with the doctor if you do not want to give a written response*)

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long? _____

Signature (*Guardian: state relationship to patient*): X_____ Date:_____