

# 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 \_\_\_\_\_ Gender: Male\_\_\_ Female\_\_\_ 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Arthritis/ Lupus	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Asthma/Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Migraine Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Immune Deficiency Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cancer _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Cataracts	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Retinal Detachment	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Macular Degeneration	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Strabismus ("wandering eye")	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Amblyopia ("lazy eye")	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Ocular allergies/ hayfever	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Ocular disease or accident	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Vision Therapy/ eye exercises	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

**HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?**

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