

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 _____
LAST FIRST MIDDLE

Today's Date ____/____/____

Preferred pronouns _____

Date of Birth ____/____/____

Address _____

Home Phone (____) _____

City & Zip _____

Work Phone (____) _____

Email _____

Mobile Phone (____) _____

How did you learn about our office? ☐ Internet Website: _____

☐ Insurance ☐ 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	☐ No ☐ Yes	☐ No ☐ Yes	_____
Heart Disease	☐ No ☐ Yes	☐ No ☐ Yes	_____
High Cholesterol	☐ No ☐ Yes	☐ No ☐ Yes	_____
Diabetes	☐ No ☐ Yes	☐ No ☐ Yes	_____
Thyroid Disease	☐ No ☐ Yes	☐ No ☐ Yes	_____
Arthritis/ Lupus	☐ No ☐ Yes	☐ No ☐ Yes	_____
Kidney Disease	☐ No ☐ Yes	☐ No ☐ Yes	_____
Asthma/Emphysema	☐ No ☐ Yes	☐ No ☐ Yes	_____
Migraine Headaches	☐ No ☐ Yes	☐ No ☐ Yes	_____
Depression	☐ No ☐ Yes	☐ No ☐ Yes	_____
Immune Deficiency Disease	☐ No ☐ Yes	☐ No ☐ Yes	_____
Cancer _____	☐ No ☐ Yes	☐ No ☐ 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	☐ No ☐ Yes	☐ No ☐ Yes	_____
Cataracts	☐ No ☐ Yes	☐ No ☐ Yes	_____
Retinal Detachment	☐ No ☐ Yes	☐ No ☐ Yes	_____
Macular Degeneration	☐ No ☐ Yes	☐ No ☐ Yes	_____
Glaucoma	☐ No ☐ Yes	☐ No ☐ Yes	_____
Strabismus ("wandering eye")	☐ No ☐ Yes	☐ No ☐ Yes	_____
Amblyopia ("lazy eye")	☐ No ☐ Yes	☐ No ☐ Yes	_____
Ocular allergies/ hayfever	☐ No ☐ Yes	☐ No ☐ Yes	_____
Ocular disease or accident	☐ No ☐ Yes	☐ No ☐ Yes	_____
Vision Therapy/ eye exercises	☐ No ☐ Yes	☐ No ☐ Yes	_____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?

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