Welcome!

Today's Date ________________

Last Name ____________________________ First ______________________ Middle _________ ☐Male ☐Female

Name you prefer to be called ______________________ Email Address ___________________________________

Birthdate ___/___/___ Age _____ Social Security Number _____/_____/_____ Home Phone # ___________________

Home Address _______________________________ City _____________________ State ______ Zip ____________

Employer _________________________ Occupation ________________________ Cell Phone # _______________

Work Address _______________________________ City _____________________ State ______ Zip ____________

Contact name in case of emergency __________________________ Phone # ____________________

Medical History

Do you have any allergies to medications? ☐No ☐Yes If yes, explain: ____________________________________

Are you currently seeing a physician for any health problems? ☐No ☐Yes

If yes, what? ____

List any medications you take (including oral contraceptives, aspirin, or over the counter medications and home remedies):

MEDICATION ____________________________ FOR ____________________________

MEDICATION ____________________________ FOR ____________________________

MEDICATION ____________________________ FOR ____________________________

Are you pregnant and/or nursing? ☐No ☐Yes If yes, how many months pregnant? ____________

Do you: ☐Currently wear contact lenses? ☐Have worn contact lens in the past

Type of contact lenses: ☐Hard ☐Soft ☐Extended Wear ☐Other How often do you replace lenses?____________

Date of Last Eye Exam _________________________ Doctor ____________________________________

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

DISEASE/CONDITION	N	Y	WHO	DISEASE/CONDITION	N	Y	WHO
Blindness	☐	☐	____________	Arthritis	☐	☐	____________
Eye/Brain Tumor	☐	☐	____________	Cancer	☐	☐	____________
Crossed Eyes	☐	☐	____________	Diabetes	☐	☐	____________
Glaucoma	☐	☐	____________	Heart Disease	☐	☐	____________
Cataract	☐	☐	____________	High Blood Pressure	☐	☐	____________
Macular Degeneration	☐	☐	____________	Kidney Disease	☐	☐	____________
Retinal Detachment/Disease	☐	☐	____________	Lupus	☐	☐	____________
Eye Growths	☐	☐	____________	Thyroid Disease	☐	☐	____________
Eye Surgery	☐	☐	____________	Other __________	☐	☐	____________

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ☐*Yes*, I would prefer to discuss my Social History with my doctor (Check box)

Do you drive? ☐No ☐Yes Do you have any visual difficulty when driving? ☐No ☐Yes Please describe:

____

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

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

Do you use illegal drugs? ☐No ☐Yes If yes, type/amount/how long: ______________________________

Have you ever been exposed to or infected with: ☐N/A ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

**** Please turn this form over & complete side two ****

Review of Systems Are you having any problems in the following areas:

SYSTEM	N	Y
CONSTITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision/Side Vision	☐	☐
Poor Distance Vision	☐	☐
Poor Near Vision	☐	☐
Distorted Vision/Halos	☐	☐
Double Vision	☐	☐
Strained / Tired Eyes	☐	☐
Flashes / Floaters in Vision	☐	☐
Eye Injury	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare / Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sties or Chalazion	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

SYSTEM	N	Y
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post – Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR / CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

Lifestyle

Check any activities that should be considered for your visual needs:

General	☐Reading	☐Detail work	☐Driving	☐Night-driving	☐Other ________________
Sports	☐Racquet Sports	☐Baseball/Basketball	☐Golf	☐Skiing	☐Other ________________
Exercise	☐Swimming	☐Biking	☐Aerobics	☐Walking/Jogging	☐Other ________________
Business	☐Computers	☐Presentations	☐Safety/Hazardous materials		☐Other ________________

Referral Whom may we thank for referring you***?***

☐VSP List ☐Yellow Pages ☐Internet: Which site? ________________________

☐Live/Work Nearby ☐Shop Nearby ☐Doctor/School Nurse

☐Friend /Relative – their name ____

Payment

Insurance / Medicare/Cal Signature on File

I certify that the information given by me in applying for Insurance / Medicare/Cal/ payments are true and correct. I request that payment of authorized Insurance / Medicare/Cal/ benefits be made to Dr Sandra Lee for any services and materials furnished. I authorize any holder of medical information about me to release to HCFA or Insurance agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown. I understand that I am responsible for the balance of fees not paid by insurance

____ ______________

Signature on File Date

Payment is Due Upon Completion of Exam Today.