

# WELCOME BACK TO OUR OFFICE



OPTOMETRIC CENTER FOR  
FAMILY VISION CARE AND VISION THERAPY  
1234 Cherry Street, San Carlos, CA 94070  
650.593.1661 www.FamilyVisionCare.Org

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_ Email \_\_\_\_\_  
Employer (or School) \_\_\_\_\_  
Occupation (or Grade) \_\_\_\_\_  
Spouse (or Parent) Name(s) \_\_\_\_\_  
Emergency Contact Number \_\_\_\_\_

### What is the major purpose of your visit?

- Annual check-up       Distance vision  
 Contact Lenses       Near vision  
 Vision Therapy/Rehab       Other

Are you satisfied with the vision & comfort of your glasses or contacts? If not, explain: \_\_\_\_\_  
\_\_\_\_\_

### Insurance Information

Vision Insurance Co. \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Subscriber SSN & Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Subscriber SNN & Birth Date \_\_\_\_\_

Do you participate in a flex spending account?

- Yes       No

Payment is due when services are rendered.

How will you settle your account today?

- Cash       Check       Credit card

I authorize payment of medical benefits to  
Family Vision Care for services rendered.

\_\_\_\_\_  
Patient, Parent, or Guardian Signature      Date

2.06 wbto

Please update your confidential history, which is critical to your vision and eye health exam.

### Patient Medical History

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Last Physical Exam Date \_\_\_\_\_

Pregnant or Nursing?       Yes       No

Any Current Medications?       Yes       No

List name(s) and purpose, including over the counter, eye drops, vitamins & birth control pills: \_\_\_\_\_  
\_\_\_\_\_

Allergies to Medications:       Yes       No

List: \_\_\_\_\_

### Have you ever been diagnosed or treated for:

- Allergies       Diabetes       TBI/ Stroke  
 Asthma       Heart Disease       Thyroid  
 Arthritis       High Blood Pressure  
 Cancer       Kidney       Other \_\_\_\_\_  
 Cholesterol       Learning /Reading Difficulties

### Patient Eye History

Age of present glasses/sun glasses: \_\_\_\_\_/\_\_\_\_\_

Do you currently wear contact lenses?       Yes       No

Hours of wear/day or day/month \_\_\_\_\_

Solution Using: \_\_\_\_\_

If you stopped wearing contacts, why? \_\_\_\_\_  
\_\_\_\_\_

New hobbies? \_\_\_\_\_

Do you..... (Check box if your answer is "Yes")

- ..Prefer not to wear your glasses at times?  
 ..Have interest in trying the latest contact lenses?  
 ..Have interest in non-surgical vision correction?  
 ..Want information on Laser Vision Correction?  
 ..Spend time outdoors? How much? \_\_\_\_\_ hrs/week  
 ..Have prescription sunglasses?  
 ..Feel bothered by bifocal lines or head posture?  
 ..Have more than one current prescription glasses?  
 ..Want thinner and lighter lenses  
 ..Experience occasional symptoms during/after computer use?  
 ..Want to improve reading/comprehension, or sports performance?  
 ..Have the need for sports goggles / safety glasses?  
 ..Have family members in need of eye care?  
 ..Have children? Names & Ages: \_\_\_\_\_

**Family Medical/Eye History (Check all that apply)**

**Is there a family history of any of the following?**

Relationship (e.g., Grandma, Uncle, etc)

- Blindness  \_\_\_\_\_
- Cataracts  \_\_\_\_\_
- Corneal Problems  \_\_\_\_\_
- Diabetes  \_\_\_\_\_
- Heart Disease  \_\_\_\_\_
- High Blood Pressure  \_\_\_\_\_
- Glaucoma  \_\_\_\_\_
- Lazy Eye / Strabismus  \_\_\_\_\_
- Macular Degeneration  \_\_\_\_\_
- Retinal Problems  \_\_\_\_\_

**For Students, Please Complete This Section**

In order to assist the doctor in evaluating visual skills needed in the learning environment, please grade, and then check all the boxes that are still of concern.

*1 - below average    2 - average    3 - advanced*  
Reading \_\_\_\_ Spelling \_\_\_\_ Penmanship \_\_\_\_  
Math \_\_\_\_ Writing \_\_\_\_ Physical Ed \_\_\_\_

- Does Not Enjoy reading
- Poor Reading Comprehension
- Prefers to be Read to
- Loses Place When Reading
- Short Attention Span
- Poor Penmanship
- Makes Errors When Copying
- Rubs or Blinks Eyes Excessively
- Squints or Turns Head to One Side
- Clumsy or Awkward
- Fatigued, Frustrated, or Day Dreams Often
- Left and Right Confusion or Reversals
- Inconsistent or Poor Sports Performance
- Teacher has Concerns about School Performance
- Variable School Performance
- Identified Hearing, Auditory, or Speech Problem
- Unusual Sensitivities to Clothing, Taste, Touch, etc
- Therapy Since Last Exam:  Occupational
  - Psycho-Educational  Physical
  - Speech  Other \_\_\_\_\_

**Patient Eye History Continued (Check all that apply)**

**Have you ever been diagnosed or treated for:**

- Cataracts  Iritis / Uveitis
- Corneal Abrasion  Lazy Eye / Strabismus
- Eye infection  Macular Degeneration
- Eye injury  Retinal Detachment
- Glaucoma  Other eye disorders

**Do you experience, with what you normally wear..?**

( glasses  contacts  no correction)

- Far Vision Blur  Near Vision Blur
- Sunlight Sensitivity  Floater/Spots
- Burning/Dryness/Tearing  Red Eyes Often
- Crossed Eye/Eye Turn  Itchiness
- Double Vision  Headaches
- Eye Strain/fatigue  Poor Night Vision
- Flashes of light
- Discomfort with Glasses or Contact Lenses

**Other Comments or Concerns**

Please note any thing else you would like to share with your doctor in the space below: