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34 VAN NESS AVENUE
SAN FRANCISCO, CA 94102

Please take a moment to answer the questions on this form.
THIS INFORMATION WILL BE KEPT IN STRICT CONFIDENCE. Thank You.

Date: ____________

Patient's Name: Mr. / Mrs. / Ms. ____________ Birthdate: ___/___/___ M ☐ or F ☐

Address ____________ Apt # ______ Home Phone (____) ________

City ____________ State ______ Zip Code ______ Work Phone (____) ________

Email (Optional) ____________ Cell Phone (____) ________

Occupation ____________ Employer ____________ SSN # (last 4 digits only) ________

PERSON RESPONSIBLE FOR BILL (Complete only if not self)

Spouse / Parent / Guardian / Other Name ____________ SSN # (last 4 digits only) ________

Address ____________ City ________ State ______ Zip ______ Phone (____)________

Occupation of Responsible Party ____________ Employer ____________ Phone (____)________

INSURANCE INFORMATION (Indicate Primary and Secondary, as applicable)

Please check your plan	Insurance ID#	Member's Name	Effective Date
☐ Vision Service Plan			
☐ Medicare			
☐ Other			

1. *A Notice of Privacy Practices, which explains the use and disclosures of my protected health information, has been made available to me. I understand I may request a printed copy at anytime.*
2. *Payment for professional services is expected upon completion of exam. Fifty percent of material fees is expected on the date of order. The balance is due on delivery of date. I agree that my insurance company may obtain and/or review my records if applicable.*

X ____________ ____________
Patient's Signature Date

PLEASE COMPLETE THE FOLLOWING

Are you currently having problems with your eyes or vision? ☐ Yes ☐ No

If yes, please explain ____________

Last complete eye examination: ____________

Are you interested in: Glasses ________ Contact Lenses ________ Lasik ________

Do you have or have you ever had:

☐ Glaucoma	☐ Lazy Eye	☐ Crossed Eyes	☐ None of the above
☐ Cataracts	☐ Retinal Disease	☐ Eye Infections	☐ Other
☐ Eye Surgery	☐ Eye Injury	☐ Prominent Eyes	

MEDICAL HISTORY

List any MEDICATIONS you are taking: ____________

List any ALLERGIES to medication: ____________

List major injuries, surgeries or hospitalizations you have had: ____________

FAMILY HISTORY

Do any of your blood relatives have:

☐ Blindness	☐ Crossed Eyes	☐ Glaucoma	☐ Macular Degeneration
☐ Retinal Problems	☐ Hypertension	☐ Heart Disease	☐ Other
☐ Cancer	☐ Thyroid	☐ Diabetes	☐ None

PLEASE TURN THIS FORM OVER AND COMPLETE THE OTHER SIDE

SOCIAL HISTORY

Do you drive?	☐ Yes ☐ No	Do you have difficulty when driving?	☐ Yes ☐ No	
Do you smoke?	☐ Yes ☐ No	Type / Amount / How Long: ______		
Do you drink alcohol?	☐ Yes ☐ No	Type / Amount / How Long: ______		
Do you use illegal drugs?	☐ Yes ☐ No	Type / Amount / How Long: ______		
Do you have or have had	☐ Gonorrhea	☐ Hepatitis	☐ HIV	☐ Syphilis

Check here if you would prefer to discuss the above directly with the doctor: ☐

REVIEW OF SYSTEMS

Do you presently or have you had any problems listed below:

EYES	YES	NO		YES	NO
Loss of Vision	☐	☐	Asthma	☐	☐
Blurred Vision	☐	☐	Bronchitis	☐	☐
Tired Eyes	☐	☐	Emphysema	☐	☐
Distorted Vision	☐	☐	Thyroid	☐	☐
Double Vision	☐	☐	Gland Condition	☐	☐
Dryness/Burning	☐	☐	Rheumatoid Arthritis	☐	☐
Sandy/Gritty Feeling	☐	☐	Muscle Pain	☐	☐
Mucous Discharge	☐	☐	Joint Pain	☐	☐
Redness	☐	☐	Diarrhea	☐	☐
Itching	☐	☐	Constipation	☐	☐
Excess Tearing	☐	☐	Anemia	☐	☐
Glare/Light Sensitivity	☐	☐	Bleeding Problems	☐	☐
Eye Pain/Soreness	☐	☐	Kidney/Bladder	☐	☐
Chronic Infection of Eye or Lid	☐	☐	Fever, Weight Gain/Loss	☐	☐
Styes or Chalazion	☐	☐	Skin Condition	☐	☐
Flashes/Floaters	☐	☐	Psychiatric	☐	☐
Headaches/Migraines	☐	☐	Allergies/Hay Fever	☐	☐
Seizures	☐	☐	Sinus Problems	☐	☐
Head Injuries	☐	☐			
Diabetes	☐	☐			
High Blood Pressure	☐	☐			
Heart Pain	☐	☐			

If you answered **YES** to any of the above or have a condition not listed, please explain:

____

____

____

____

____

Whom may we thank for referring you? ______________________________

______________________________ Doctor's Signature

______________________________ Date