San Ramon Family Optometry
175 Market Place
San Ramon, CA 94583
925-275-0202

Today's Date:___________________
Patient's Name:_________________
Date of Birth:___________________

Patient History and Information

Main reason for visit:	
Which eye (circle) Left / Right / Both	**Onset** (when did it start)
Duration (how long)	**Timing** (how often)
Context (when do you notice it)	
Severity (circle) Mild / Mod / Severe	**Relief Factors** (what helps)
Circle all that apply: Blurred vision Night blur Double vision Itchiness Tearing Pregnant Nursing Eye strain Tired eyes Squinting Pain Redness Dizziness Floaters Light flashes Light sensitivity Eye injury: Details_______________	
# of hours per day you spend looking at an electronic device	

Medical and Eye History

For Returning Patients: Initial here if there are no changes to your health history__

Any of the following conditions?	Self	Family	Relationship
Dry Eyes	Y N	Y N	
Glaucoma	Y N	Y N	
Macular Degeneration	Y N	Y N	
Retinal Disease	Y N	Y N	
Blindness	Y N	Y N	
Strabismus (lazy eye)	Y N	Y N	
Amblyopia	Y N	Y N	
Diabetes (HbA1c:____& date:______)	Y N	Y N	
High Cholesterol	Y N	Y N	
High Blood Pressure	Y N	Y N	
Heart Disease	Y N	Y N	
Cancer	Y N	Y N	
Psychiatric	Y N	Y N	
Seasonal Allergies	Y N	Y N	
Asthma	Y N	Y N	
Other-please specify:	Y N	Y N	

Last Eye Exam	**Last Eye Doctor**
Last Physical Exam	**Primary Care Physician**
Recent Surgeries (what/when/where)	
Headaches (if yes,when/how often)	
List current medications	
Allergies to medications	
Tobacco use (circle) Prior / Current / Never	**Alcohol use** (circle) Prior / Current / Never
Special needs we need to be aware of	

Contact Lenses (if applicable)

What brand of contact lenses do you wear	
How long per day do you wear them	**How often do you replace them**