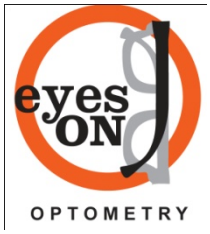
Today's Date_____

Patient History Questionnaire



808 J Street
Sacramento

Name_____ DOB_____ Age_____ Sex _M_or_F_
Address_____ City_____ State_____Zip_____
Phone (Home)_____ (Work)_____(Cell)_____
Please circle the phone number you would like to use as your primary daytime contact number.
Email_____(optional) Referred by_____

Insurance Information

☐ None Primary Subscriber's name_____

Vision Plan? ☐Vision Service Plan(VSP) ☐Davis Vision ☐Medical Eye Services(MES) ☐Superior Vision
☐ Spectera(Optum Health) ☐Other_____

Primary Subscriber's DOB_____ and last four digits of their social security number_____

Medical Information

Describe your general health_____

Do you have any problems with any of the following systems? (please circle yes or no)

Gastrointestinal	yes/no	Nervous	yes/no	Endocrine (glands)	yes/no
Ear/Nose/Throat	yes/no	Urinary	yes/no	Blood/Lymph	yes/no
Cardiovascular	yes/no	Eyes	yes/no	Allergic/Immunologic	yes/no
Respiratory	yes/no	Headaches	yes/no	Integumentary (skin)	yes/no
High blood pressure	yes/no	Mental	yes/no	Muscles/Bone	yes/no

If yes to any please explain_____
Do you have Diabetes? yes/no Type _____ Date of diagnosis_____
Allergies to medication? yes/no Which?_____ Reactions_____
Other health problems?_____
List current medication(s) ☐check if none_____
Do you smoke? yes/no If female, are you pregnant or nursing? yes/no _____
Please list any operations you have had with their dates_____
Name of family doctor_____ Last visit_____ Last tetanus shot_____

Personal Eye Information

Date of last eye exam_____ Were you dilated? yes/no

Have you ever been diagnosed with any of the following?:

Macular Degeneration	yes/no	Glaucoma	yes/no	Diabetic Retinopathy	yes/no
Retinal detachment	yes/no	Cataracts	yes/no	Hypertensive Retinopathy	yes/no

Do you have dry eyes? yes/no History of eye injury? yes/no Kind?_____Date?_____
History if eye surgery? yes/no Type_____ Date_____
Do you wear glasses? yes/no Contact lenses? yes/no Type/Brand_____
How many hours a day are you on the computer?_____ Do you have eyestrain as a result? yes/no
Additional vision/eye health information:_____

Family Medical and Eye Health History

High blood pressure	yes/no	Relation_____	Macular degeneration	yes/no	Relation_____
Diabetes	yes/no	Relation_____	Retinal detachment	yes/no	Relation_____
Glaucoma	yes/no	Relation_____	Cataracts	yes/no	Relation_____

Doctor Use Only

Reviewed by:_____ Date_____