brentwood**eye**care
an optometry group

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Welcome to Our Office

Patient's name

Mr. Mrs. Ms. Miss. _____

Today's Date _____

Spouse or Parent _____

Child(ren)'s Name(s) _____ Age _____

_____ Age _____

Mailing Address _____

City, State, Zip _____

Date of birth._____ Age _____ Sex : F M

Home Phone _____ Cell _____

Work Phone _____ ext. _____

PATIENT'S MEDICAL HISTORY

Allergies	Arthritis	Heart Disease
Asthma	Cancer	Skin Disorder
Diabetes	Cataracts	High Blood Pressure
Eye Injury	Eye Surgery	Glaucoma
Nerves	Kidney Problems	

Other _____

CURRENT MEDICATIONS (Rx or over the counter)

	Medication Name
Antihistamines	_____
Blood Pressure Pills	_____
Diuretic (water pill)	_____
Oral Contraceptives	_____
Sleeping Tablets	_____
Eye Drops	_____
Others	_____
Allergies to Medicines	_____
Date of Last Physical Exam	_____
Name of Physician	_____
Date of Last Eye Exam	_____

FAMILY MEDICAL HISTORY

	Relationship to Patient
Blindness	_____
Glaucoma	_____
Diabetes	_____
High Cholesterol	_____
Other	_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

Yes, I would like to discuss my Social History information directly with my doctor.

Yes No Do you use tobacco products?

Yes No Do you drink alcohol?

Employer (or School) _____

Occupation (or grade) _____

What is the major purpose of this visit? _____

_____

Any problems with your present contact lenses or glasses? _____

_____

Vision Insurance: ☐ Medicare
☐ VSP
☐ None

Member ID/SS# _____

Member ID/SS# _____

Do you have double coverage? ☐ Yes ☐ No

How will you settle your account today?

☐ Check ☐ Credit Card ☐ Cash

Do you experience… (check those that apply)

Burning	Uncomfortable Glasses
Itchiness	Sudden Loss of Vision
Nausea	Sensitivity to Light
Watery Eyes	Fainting or Dizziness
Double Vision	Blurry Distance Vision
Flashes of Light	Blurry Near
Glare or Reflection	Gritty Feeling in Eyes
Soreness	Objects Floating in Vision
Eye Strain	Trouble Seeing at Night
Headaches	Dryness
Redness	Other

VISUAL NEEDS

Do You … (check the box if your answer is yes)

- Work at a computer for long periods of time?
- Have only one pair of glasses?
- Want information on thinner, lighter lenses?
- Use bifocals?
- Want information on lineless bifocals?
- Prefer not to wear your glasses at times?
- Spend a lot of time outdoors?
- Ever find a need for prescription sunglasses?
- Have problems with glare or reflections (ex: night driving?
- Do work requiring safety glasses?
- Participate in sport activities? What? _____
- Want more information about corrective vision surgery?
- Wear or ever tried wearing contacts? What kind? ____

By signing below, I agree to accept financial responsibility for all services and materials not covered by my vision insurance provider.

Signature: _____ **Date:** _____

By signing below, I agree to accept financial responsibility for all services and materials not covered by my vision insurance provider.

Signature: _____ **Date:** _____