

Los Gatos Eye Care



PATIENT HISTORY AND INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
Street Name
City State Zip Code

Birthdate: _____ Age: _____ Sex: Male Female Social Security Number: _____

Home Telephone: _____ Work/Cell Telephone: _____

Email: _____

Date of Last Eye Exam: _____ Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone Number: _____

Medical Insurance Carrier: _____ PPO / PIO / HMO / Other

Do you have kids? Y/N If so, how many and what are their names? _____

How were you referred to our office? Live in neighborhood/VSP website/lgeyecare website/friend or co-worker _____

CONTACT LENS HISTORY:

Have you ever tried to wear contact lenses? Yes No Reason for stopping _____

Do you currently wear contact lenses? Yes No Since _____

Contact Lens Brand: _____ Contact Lens Care System: _____

◆ If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

SPECTACLE LENS HISTORY:

Do you currently wear glasses? Yes No Since _____ Full Time Part Time Distance Close

Glasses Owned Single Vision Bifocals Trifocals Progressive Computer

Back-up Glasses Safety Glasses Sports Glasses

Do you wear sunglasses? Yes No Are your sunglasses your current prescription? Yes No

Which of the following do you do regularly?

Night Driving

Work Outdoors

Commute 20+ minutes by car

Work with small objects

Work under fluorescent light

Read for long periods

Work on a computer

Travel on airplanes

Watch television 3+ hours per day

Frequently alternate between indoors and outdoors

Work at a desk

Other _____

List any sports or hobbies that you may participate in:

SOCIAL HISTORY

Do you engage in regular exercise? Yes No

Do you drink alcohol? Yes No

Do you smoke? Yes No

Please take a few minutes to answer the brief health questionnaire on the reverse

(next page)

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MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

Yes	No		Yes	No		Yes	No	
		Glare/Light Sensitivity			Itching			Blurred Vision Distance
		Headaches			Mucous Discharge			Blurred Vision Near
		Tired Eyes			Drooping Eyelid			Distorted Vision (halos)
		Amblyopia (Lazy Eye)			Redness			Double Vision
		Burning			Sandy or Gritty Feeling			Floaters or Spots
		Dryness			Crossed Eyes			Fluctuating Vision
		Excess Tearing/Watering			Infection of Eye or Lid			Loss of Vision
		Eye Pain or Soreness						Loss of Side Vision

GENERAL HEALTH CONDITION

Yes	No		Yes	No		Yes	No	
		Fever			Respiratory (asthma, emphysema)			Skin Neurological (acne, cancer)
		Weight Loss			Gastrointestinal			Endocrine (diabetes, thyroid)
		Ears, Nose, Throat			Kidney			Blood/Lymph (cholesterol/anemia)
		Cardiovascular (high blood pressure, etc.)			Muscles, Bones, Joints (arthritis)			Allergic/Immunologic

Past Illnesses or Injuries: _____

Current Medications (including vitamins and herbal supplements): _____

Past Surgeries (including refractive surgeries): _____

Medications that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

Yes	No		Who	Yes	No		Who
		Amblyopia (Lazy Eye)				Arthritis	
		Blindness				Cancer	
		Cataract				Diabetes	
		Color Deficiency				Heart Disease	
		Glaucoma				High Blood Pressure	
		Macular Degeneration				Kidney Disease	
		Retinal Detachment				Stroke	
		Strabismus (Eye Turn)				Thyroid Disease	

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide our doctors and staff to your specific needs. We look forward to seeing you for your examination and feel free to let us know if you have any other needs or concerns we have not addressed.

Doctor's Signature

Date