

Los Gatos Eye Care

PATIENT HISTORY AND INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
Street Name

City State Zip Code

Birthdate _____ Sex: Male Female Social Security Number: _____

Home Telephone: _____ Work Telephone: _____ Email: _____

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

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 _____

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

◆ Type and brand of contact lenses _____

◆ How many hours/day? _____ How many days/week? _____ Today's wearing time? _____

What Contact Lens Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

SPECTACLE LENS HISTORY:

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

Glasses Owned Single Vision Bifocals Trifocals Progressive

Back-up Glasses Safety Glasses Sports Glasses

Have you had trouble in the past with glasses? _____

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

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol? Yes No

Do you smoke? Yes No

SPECIAL EYEWEAR NEEDS:

Computer (special prescriptions, special anti-glare tints or coatings)

Occupational (mechanics, plumbers, pilots)

Safety Glasses (gardening, woodworking, welding)

Sports (racquet sports, motorcycle)

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

(OVER)

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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: _____

Past Surgeries: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

Yes	No		Yes	No	
		Amblyopia (Lazy Eye)			Arthritis
		Blindness			Cancer
		Cataract			Diabetes
		Color Blindness			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 eyecare. 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.

Los Gatos Eye Care Staff

Doctor Signature

Date