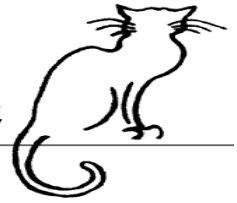


# Los Gatos Eye Care



## PATIENT HISTORY AND INFORMATION

DATE \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
LAST FIRST MI NICKNAME  
 Address \_\_\_\_\_ Sex  Male  Female Age \_\_\_\_\_  
STREET NAME  
 \_\_\_\_\_ Social Security Number \_\_\_\_\_  
CITY STATE ZIPCODE  
 Home Telephone \_\_\_\_\_ Work/Cell Telephone \_\_\_\_\_  
 Date of Last Eye Exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email \_\_\_\_\_  
 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 did you hear about us? Live in neighborhood / VSP website / lgeyecare website / friend or co-worker \_\_\_\_\_

## GLASSES HISTORY

Do you wear glasses?  Yes  No  
 a) For:  Near  Distance  Both  
 b)  Single Vision  Bifocals  
 Progressive  Trifocals  
 c) Any Problems? \_\_\_\_\_  
 d) Do you wear sunglasses?  Yes  No  
 e) Are your sunglasses prescription?  Yes  No

## CONTACT LENS HISTORY

Do you wear contacts?  Yes  No  
 Reason for stopping \_\_\_\_\_  
 a)  Full Time  Part Time  Rarely  
 b) Type of Contacts?  
 Daily Wear  Extended Wear  
 Soft Toric  Gas Permeable  
 c) What cleaning solution do you use? \_\_\_\_\_  
 d) If you do not wear contacts, are you interested in trying them?  
 Yes  No

## SOCIAL HISTORY

Do you engage in regular exercise?  Yes  No  
 Do you drink alcohol?  Yes  No  
 Do you smoke?  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 you participate in \_\_\_\_\_

## OCULAR SURFACE DISEASE HISTORY

Do your eyes ever feel or do you experience:

Never

Slight

Moderate

Severe

	Never	Slight	Moderate	Severe
Gritty or sandy sensation?				
Pain or soreness?				
Fluctuating vision?				
Occasional tearing?				
Blurred vision while reading or computer use?				
Discomfort in windy conditions?				
Discomfort in Heating/Air Conditioned areas?				

## FAMILY MEDICAL HISTORY

### EYE DISEASES

	Yes	No	Who		Yes	No	Who
Amblyopia (Lazy Eye)				Color Blindness			
Eye Tumor				Glaucoma			
Blindness				Macular Degeneration			
Cataract(s)				Retinal Detachment			

### SYSTEMIC DISEASES

	Yes	No	Who		Yes	No	Who
Arthritis				High Cholesterol			
Cancer				Stroke			
Diabetes				Kidney Disease			
Heart Disease				Lupus			
High Blood Pressure				Thyroid Disease			

## PATIENT MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Allergies (seasonal)			Glaucoma			Computer Eye Strain		
Excessive Weight Changes			Cataract(s)			Strabismus (Crossed Eyes)		
Ear, Nose, Throat			Macular Degeneration			Blurred Vision at Distance		
High Blood Pressure			Retinal Detachment			Blurred Vision at Near		
Asthma/Breathing Problems			Color Blindness			Distorted Vision (halos)		
Stomach Problems			Glare/Light Sensitivity			Double Vision		
Arthritis/Osteoporosis			Tired Eyes			Floaters or Spots		
Skin Problems			Amblyopia			Fluctuating Vision		
MS/Seizures			Burning Eyes			Loss of Vision		
Anxiety/Depression			Dryness			Loss of Side Vision		
Kidney Problems			Excess Tearing/Watering					
Diabetes			Eye Pain/Soreness					
Thyroid Problems			Itching					
Anemia/Blood Disorders			Mucous Discharge					
Lyme Disease			Sandy or Gritty Feeling					
HIV/Herpes			Ptosis (drooping eyelid)					
Cancer (What type?):			Redness					

Eye injuries, infections or surgeries (including LASIK) \_\_\_\_\_

Any other surgeries \_\_\_\_\_

Medications that cause reactions or sensitivities \_\_\_\_\_

Specific Allergies \_\_\_\_\_

Current Medications (including vitamins & herbal supplements) \_\_\_\_\_

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 please feel free to let us know if you have any other needs or concerns we have not addressed.

*This form was reviewed and electronically signed in the Electronic Health Records (EHR) system.*