THE EYE SHOP
optometry

☐Mr. ☐Mrs. ☐Ms. ☐Dr. DATE OF BIRTH_____

LAST NAME_____ FIRST_____ MI_____ MARRIED:☐Y ☐N SEX: ☐M ☐F

ADDRESS: _____ SOCIAL SECURITY #: _____

CITY, STATE, ZIP:_____ OCCUPATION:_____

CONTACT INFORMATION:

Cell: _____

Home: _____

Work: _____

Email: _____

How did you find our office?

_____

If referred, who may we thank?

_____

NAME OF MEDICAL DOCTOR:

_____

City/Phone#: _____

Person to contact in case of emergency:

Name: _____

Phone#: _____

Relationship: _____

EYE & MEDICAL HISTORY

DATE OF LAST EYE EXAM: _____Where?_____ Last eye dilation: _____ LAST PHYSICAL: _____

List any medications currently taken (including birth control, over-the-counter medications/vitamins, supplements, home remedies):

_____

_____

Allergies (medications, food, etc.):_____

Are you pregnant or nursing? ☐ Yes ☐ No If pregnant, for how many months? _____

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your current lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No

If yes: Which brand do you use? _____ How often do you replace them? _____

Which solution do you use? _____ How old is your current pair? _____

Have you ever had refractive eye surgery? ☐ Yes ☐ No If yes, which type? ☐LASIK ☐PRK ☐RK When?_____

PERSONAL/FAMILY HISTORY: please answer the following regarding you and your immediate family (parents, grandparents, siblings, children) for the following

	You		Family		
	Yes	**No**	**Yes**	**No**	**Relationship**
Blindness/Loss of Vision	☐	☐	☐	☐	_____
Crossed eyes	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	_____
Macular degeneration	☐	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	_____
High blood pressure	☐	☐	☐	☐	_____
High cholesterol	☐	☐	☐	☐	_____
Other_____	☐	☐	☐	☐	_____
Major injuries/surgeries	☐	☐	*Please describe*		_____

SOCIAL HISTORY (If you do not wish to give a written response, please discuss with the clinician)

Do you drive? ☐ Yes ☐ No If yes, do you have difficulty seeing while driving? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? _____

REVIEW OF SYSTEMS

Do you currently have or ever had any problems in the following areas:

	YES	NO		YES	NO
Constitutional			***Ear/Nose/ Mouth/Throat***		
Fever/weight changes	☐	☐	Allergy/Hay Fever	☐	☐
Integumentary (Skin)			Sinus congestion	☐	☐
Rosacea	☐	☐	Dry throat/mouth	☐	☐
Neurological			***Respiratory***		
Headaches	☐	☐	Asthma	☐	☐
Migraines	☐	☐	Emphysema	☐	☐
Seizures	☐	☐	Chronic bronchitis	☐	☐
Eyes			***Vascular/Cardiovasc***		
Blurred vision	☐	☐	Diabetes	☐	☐
Distorted vision/halos	☐	☐	Vascular disease	☐	☐
Loss of side vision	☐	☐	Elevated cholesterol	☐	☐
Double vision	☐	☐	High blood pressure	☐	☐
Eye fatigue/tiredness	☐	☐	***Gastrointestinal***		
Redness	☐	☐	Chronic diarrhea	☐	☐
Dryness	☐	☐	***Genitourinary***		
Sandy/gritty feeling	☐	☐	Kidney/bladder	☐	☐
Foreign body sensation	☐	☐	***Bones/Joints/Muscles***		
Watering/tearing	☐	☐	Arthritis	☐	☐
Burning	☐	☐	***Lymphatic/Hematologic***		
Itching	☐	☐	Anemia	☐	☐
Mucous discharge	☐	☐	Blood/bleeding problems	☐	☐
Glare/light sensitivity	☐	☐	***Endocrine***		
Eye pain/soreness	☐	☐	Thyroid	☐	☐
Injury/trauma	☐	☐	***Psychiatric/Depression***		
Flashes of light	☐	☐	***Other*** _____		
Floaters in vision	☐	☐	_____		

NOTICE OF PRIVACY PRACTICES

I have received a copy of and/or read South Pasadena Eye Care Optometry/Justin Hu, O.D.'s Notice of Privacy Practices.

NOTICE OF FINANCIAL POLICY

Payment is expected at the time of service. Insurance co-payments and amount due is estimated at the time of service. If insurance is being used, I understand that I am responsible for any fees for services and materials not covered or paid for by my insurance including co-payments and deductibles. I authorize South Pasadena Eye Care Optometry and Justin Hu, O.D. to release any medical information necessary in order to process insurance claims billed on my behalf.

I will notify you of any changes in address, phone number, insurances, etc.

A $40 service charge will be collected on any checks returned due to insufficient funds.

PLEASE SIGN BELOW:

Patient or Parent/Guardian (if under 18) _____ **Date** _____

Reviewed at annual exam:

Clinician: _____ Date _____

Clinician: _____ Date _____

Clinician: _____ Date _____