THANK YOU FOR SELECTING PRECISION EYECARE CENTERS TO PROVIDE YOUR VISION AND HEALTH NEEDS.

Please take a moment to complete our patient medical history questionnaire

Name (Dr / Mr / Ms / Miss / Mrs) _____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone: Home _____ **Work** _____ **Ext** _____ **Email** _____

Date of Birth ___/___/___ **SSN** _____ **Employer** _____

Occupation or Grade Level _____

Spouse or Domestic Partner _____ **SSN** _____

Last Medical Exam ___/___ **by Dr.** _____ **Medical Insurance** _____

Last Eye Exam ___/___ **by Dr.** _____ **Vision Insurance** _____

How did you hear about our office? ☐ Insurance Listing ☐ Yellow Pages ☐ Referred by _____

PERSONAL EYE HISTORY

	N	Y
Have you had any eye surgeries? Type _____ Date _____	☐	☐
Have you had any eye injuries or infections? Explain _____	☐	☐
Do you wear glasses? If yes, for what purpose: ☐ Distance ☐ Reading ☐ All Times	☐	☐
Do you have problems with glare?	☐	☐
Do you use a computer?	☐	☐
Do you wear contact lenses? ☐ Soft ☐ Extended Wear ☐ Rigid	☐	☐

Frequency of contact lens wear:
☐ All day ☐ 3-4 times a week ☐ Occasionally

	N	Y
Are you interested in:		
Contact Lenses	☐	☐
Changing your eye color	☐	☐
Laser corrective surgery?	☐	☐
Do you have:		
Glaucoma	☐	☐
Cataracts	☐	☐
Dry eyes	☐	☐
Macular Degeneration	☐	☐
Other eye problems:	☐	☐

_____
_____
_____
_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this directly with the doctor if you prefer.
☐ Yes, I would prefer to discuss my Social History information directly with my doctor (please check)

	N	Y	
Do you use tobacco products?	☐	☐	If yes, type/amount/how long: _____
Do you drink alcohol?	☐	☐	If yes, type/amount/how long: _____
Do you use illegal/social drugs?	☐	☐	If yes, type/amount/how long: _____
Have you ever been exposed to any infectious diseases?	☐	☐	If yes, please indicate: ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Other _____

To better understand your eyewear needs, please indicate what activities you are involved in (please circle):

Biking / Golf / Fishing / Snowboarding or Skiing / Hunting / Sewing or Knitting / Tennis / Baseball or Softball

Racquetball / Other: _____

PLEASE TURN PAGE OVER

PERSONAL MEDICAL INFORMATION

Do you have any allergies to medications? ☐No ☐ Yes

Explain:_____

List any medications you take (including contraceptives, aspirin, over the counter medications, and homeopathic remedies):

_____

List any major injuries and surgeries you have had:_____

Do you currently, or have you had problems in the following systems?

	N	Y		N	Y
CONSTITUTIONAL			**EARS, NOSE, THROAT**		
Fever, Weight Loss/Gain	☐	☐	Allergies/Hay Fever	☐	☐
INTEGUMENTARY (skin)	☐	☐	Sinus Congestion	☐	☐
NEUROLOGICAL			**VASCULAR**		
Headaches	☐	☐	Diabetes	☐	☐
Migraines	☐	☐	High Blood Pressure	☐	☐
Seizures	☐	☐	**GASTROINTESTINAL**	☐	☐
ENDOCRINE			**LYMPHATIC/HEMATOLOGIC**		
Thyroid/Other Glands	☐	☐	Anemia/Bleeding Probs	☐	☐
RESPIRATORY			**PSYCHIATRIC**	☐	☐
Asthma	☐	☐	**GENITOURINARY**	☐	☐
Bronchitis	☐	☐	**BONES/JOINTS/MUSCLES**		
Emphysema	☐	☐	Arthritis/Joint Pain	☐	☐
PREGNANT OR NURSING	☐	☐	**ALLERGIC/IMMUNOLOGIC**	☐	☐

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings; living or deceased) for the following conditions:

DISEASE/CONDITION	N	Y	**RELATIONSHIP TO YOU**
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Other: _____	☐	☐	_____

If you answered yes to any of the above, please explain: _____

_____

_____

_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have vision insurance coverage with_____ and medical insurance coverage with_____ and assign directly to El Camino Optometric Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Date

_____

Relationship

_____ History Reviewed No Changes
_____ History Reviewed No Changes
_____ History Reviewed No Changes