VISION ONE OPTOMETRY
of West Covina, Inc.

Welcome to our office

Name _____ Today's Date: ____/____/____

Address: _____ Phone: _____

_____ Work Phone: _____

Birth Date: ____/____/____ Social Security #: ____/____/____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Sex: _____ Occupation: _____ Last Medical Exam: ____/____/____

Reason for visit: _____

Medical History

Do you have any allergies to medications? ☐ no ☐ yes if yes, explain: _____

_____

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

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lesnes? _____

Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lesnes? _____

Do you have distance blur? ☐ no ☐ yes Do you have near blur? ☐ no ☐ yes

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other Are the comfortable? ☐ yes ☐ no

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	

✳ *Please turn this form over and complete side two* ✳

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer

☐ Yes, I would prefer to dicuss my Social History information directly with my Doctor (check box)

Do you Drive? ☐ no ☐ yes If yes, do you have visiual difficulty when driving? ☐ no ☐ yes If yes, please describe:

_____

Do you use tobbaco products? ☐ no ☐ yes If yes, type / amount / how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type / amount / how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss /Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migranes	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foregin Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/ Mouth	☐	☐	☐
RESPITORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Gentials / Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

Who may we thank for referring you to this office?

Name: _____ Circle one: Family Friend Phone Book Ad Reminder Card

1) Patient's Initials _____
Doctor's Initials _____
Date _____

2) Patient's Initials _____
Doctor's Initials _____
Date _____

3) Patient's Initials _____
Doctor's Initials _____
Date _____

4) Patient's Initials _____
Doctor's Initials _____
Date _____