

WELCOME TO OUR OFFICE

South County Eye Care Optometric Group
23002 Lake Center Drive, Lake Forest CA 92630

This personal vision and health information will help us give you the most complete and thorough vision examination possible. All information is of course, confidential.

Patient's Name _____ Nickname _____
Address _____
City _____ Zip _____
Phone No. (home) () _____ (work) () _____
E-Mail Address: _____
Age: _____ Birthdate: _____ Soc. Sec. # _____
Employed by _____
Occupation _____
Age of children living at home _____
Spouse's Name _____
Whom may we thank for the referral? _____

MEDICAL HISTORY:

Do you have any allergies to medications? Yes No
Explain: _____
List any medications that you take (including oral contraceptives, aspirin, and over the counter medications) and their purpose: _____

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

Are you pregnant or nursing? Yes No
Do you wear glasses? Yes No How old are they? _____
Do you wear contact lenses? Yes No Type and age? _____

FAMILY HISTORY:

Please note any family history for the following conditions:

Disease/Condition	Yes	No	Relationship to you
Blindness	Yes	No	_____
Cataract	Yes	No	_____
Crossed Eyes	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment/Disease	Yes	No	_____
Arthritis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Lupus	Yes	No	_____
Thyroid Disease	Yes	No	_____
Other	Yes	No	_____

SOCIAL HISTORY:

Do you use tobacco products? Yes No Amount/How long? _____
Do you drink alcohol Yes No Amount/How long? _____
Do you use illegal drugs? Yes No Amount/How long? _____
Have you ever been infected with Gonorrhea/Hepatitis/HIV/Syphilis? Yes No

REVIEW OF SYSTEMS: Do you currently or have you had problems in these areas?

Constitutional	Yes	No	Ear/Nose/Throat/Mouth	Yes	No
Fever, Weight Loss/Gain	Yes	No	Allergies	Yes	No
Integumentary	Yes	No	Sinus Congestion	Yes	No
Neurological			Runny Nose	Yes	No
Headaches	Yes	No	Post-Nasal Drip	Yes	No
Migraines	Yes	No	Chronic cough	Yes	No
Seizures	Yes	No	Dry Throat	Yes	No
Eyes/Vision			Respiratory		
Loss of vision	Yes	No	Asthma	Yes	No
Blurred vision	Yes	No	Bronchitis	Yes	No
Distorted vision/halos	Yes	No	Emphysema	Yes	No
Loss of side vision	Yes	No	Vascular/Cardiovascular		
Double vision	Yes	No	Diabetes	Yes	No
Dryness	Yes	No	Heart pain	Yes	No
Mucous Discharge	Yes	No	High blood pressure	Yes	No
Redness	Yes	No	Vascular Disease	Yes	No
Sandy/Gritty Feeling	Yes	No	Gastrointestinal		
Itching	Yes	No	Diarrhea	Yes	No
Burning	Yes	No	Constipation	Yes	No
Foreign body sensation	Yes	No	Genitourinary		
Excess tearing/Watering	Yes	No	Genitals/Kidney/Bladder	Yes	No
Glare/Light Sensitivity	Yes	No	Bones/Joints/Muscles		
Eye pain/Soreness	Yes	No	Rheumatoid Arthritis	Yes	No
Chronic eye lid infection	Yes	No	Muscle pain	Yes	No
Styes/Chalazion	Yes	No	Joint Pain	Yes	No
Flashes/Floaters	Yes	No	Lymphatic/Hematologic		
Tired Eyes	Yes	No	Anemia	Yes	No
Endocrine	Yes	No	Bleeding problems	Yes	No
Thyroid/Other Glands	Yes	No	Allergic/Psychiatric	Yes	No

If you answered YES to any of the above please explain below:

Vision Insurance Co. _____
Member's Name: _____ Soc. Sec# _____
Medical Insurance Co. _____ HMO / PPO / EPO
Policy # _____ Phone () _____
We have a list of medical/vision insurances that we bill directly for services rendered. If your insurance does not provide payment within 60 days, **you are responsible** to pay in full. If your insurance is not on the list, please ask us for a "super bill" so that you may submit to your insurance directly for reimbursement. You are responsible to pay in full at the time products or services are provided.

Signature _____

(Office Use Only)
Name _____
Address _____
M F _____
Nickname _____
Age (HM) _____
(WK) _____
Date _____