Welcome to

FAMILY OPTOMETRY OF IRVINE

PATIENT QUESTIONNAIRE

FIRST NAME	LAST NAME	DATE OF BIRTH	AGE	SEX M / F

STREET ADDRESS	CITY	ZIP

HOME PHONE	CELL PHONE	EMAIL (for receipts and exam recalls)

WORK PHONE	OCCUPATION	EMPLOYER

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	HOW DID YOU HEAR ABOUT US?

VISION PLAN

(for routine eye exams, glasses and contacts)

VSP EYEMED MES OTHER:	MEMBER'S NAME	
YOUR RELATIONSHIP TO MEMBER SELF SPOUSE CHILD OTHER	MEMBER'S DATE OF BIRTH	MEMBER'S LAST 4 SS or ID NUMBER

MEDICAL / HEALTH PLAN

(for non-routine medical services)

NAME OF INSURANCE	MEMBER'S NAME	
YOUR RELATIONSHIP TO MEMBER SELF SPOUSE CHILD OTHER	MEMBER'S DATE OF BIRTH	MEMBER'S ID NUMBER

PERSONAL EYE SYMPTOMS

Please check all that apply

☐ BLURRY DISTANCE VISION	☐ DRYNESS	☐ ITCHING	☐ DOUBLE VISION
☐ BLURRY NEAR VISION	☐ REDNESS	☐ PAIN	☐ EYE FATIGUE
☐ BLURRY COMPUTER VISION	☐ BURNING	☐ DISCHARGE	☐ FLASHES or FLOATERS

PERSONAL AND FAMILY EYE HEALTH

Please check all that apply	SELF	RELATIVE		SELF	RELATIVE
MACULAR DEGENERATION	☐	☐	EYE INJURY	☐	☐
RETINAL DETACHMENT	☐	☐	EYE SURGERY	☐	☐
GLAUCOMA (eye pressure)	☐	☐	WHAT TYPE? _____		
CATARACTS (cloudy lens)	☐	☐	OTHER:	☐	☐

PERSONAL AND FAMILY MEDICAL HISTORY

Please check all that apply	SELF	RELATIVE		SELF	RELATIVE
DIABETES TYPE 1 or 2	☐	☐	BLOOD / LYMPH	☐	☐
HIGH BLOOD PRESSURE	☐	☐	GASTROINTESTINAL	☐	☐
CARDIOVASCULAR ex-cholesterol	☐	☐	NERVOUS SYSTEM	☐	☐
HEADACHES ex-migraines	☐	☐	INTEGUMENTARY ex-skin	☐	☐
ENDOCRINE ex-thyroid	☐	☐	MENTAL	☐	☐
RESPIRATORY	☐	☐	URINARY	☐	☐
EAR / NOSE / THROAT	☐	☐	OTHER:	☐	☐

NAME OF FAMILY DOCTOR:	LAST PHYSICAL EXAM:
NAME OF CURRENT MEDICATION(S):	REASON FOR MEDICATION(S):
DO YOU HAVE ALLERGIES TO MEDICATIONS ☐ YES ☐ NO	WHAT TYPE OF REACTION?
HAVE YOU HAD ANY OPERATIONS? ☐ YES ☐ NO	WHAT TYPE? _____

GLASSES

DO YOU WEAR GLASSES? ☐ YES ☐ NO

HOW OLD IS YOUR PRESCRIPTION? _____ YEARS

CONTACT LENSES

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

IF YES, WHAT TYPE? ☐ SOFT ☐ GAS PERMEABLE

CONTACT LENS BRAND: _____

LENS POWER - RIGHT _____ LEFT _____

DISTANCE VISION ☐ GOOD ☐ FAIR ☐ POOR

NEAR VISION ☐ GOOD ☐ FAIR ☐ POOR

COMFORT ☐ GOOD ☐ FAIR ☐ POOR

CONTACTS ARE WORN ☐ DAILY ☐ OCCASIONALLY

MAXIMUM TIME WORN PER DAY: _____ HOURS

DO YOU SWIM WITH CONTACTS? ☐ YES ☐ NO

LENSES REPLACED EVERY: ☐ DAY ☐ ____ WEEKS ☐ MONTH ☐ OTHER

DO YOU RUB YOUR LENSES CLEAN? ☐ YES ☐ NO

DO YOU SWIM WITH CONTACTS? ☐ YES ☐ NO

DO YOU PLAY SPORTS WITH CONTACTS? ☐ YES ☐ NO

ELECTRONIC DEVICES

FREQUENTLY USED DEVICES:	ESTIMATE HOURS USED PER DAY				APPROXIMATE DISTANCE FROM EYE TO SCREEN
☐ DESK TOP	☐ 0 - 2 HOURS	☐ 2 - 6 HOURS	☐ 6 - 8 HOURS	☐ 8+ HOURS	
☐ LAPTOP	☐ 0 - 2 HOURS	☐ 2 - 6 HOURS	☐ 6 - 8 HOURS	☐ 8+ HOURS	
☐ TABLET	☐ 0 - 2 HOURS	☐ 2 - 6 HOURS	☐ 6 - 8 HOURS	☐ 8+ HOURS	
☐ CELL PHONE	☐ 0 - 2 HOURS	☐ 2 - 6 HOURS	☐ 6 - 8 HOURS	☐ 8+ HOURS	
☐ I NEED TO SEE BOTH NEAR AND FAR WHEN I AM WORKING. ☐ I PRIMARILY FOCUS ON CLOSE OBJECTS WHEN I AM WORKING.					

DO YOU SMOKE? ☐ YES ☐ NO	HOW MANY CAFFEINATED BEVERAGES DO YOU DRINK PER DAY? _____
HOW MANY GLASSES OF WATER DO YOU DRINK PER DAY? _____	HOW MANY ALCOHOLIC BEVERAGES DO YOU DRINK PER WEEK? _____

I have received a copy of the HIPAA (Notice of Privacy Practices) notice. Initial _____	TODAY'S DATE:
SIGNATURE (PARENT / GUARDIAN SIGNATURE IF PATIENT IS A MINOR)	

For office use only:	*Reviewed by:*	*Date:*	*Reviewed by:*	*Date:*
	Reviewed by:	*Date:*	*Reviewed by:*	*Date:*