Welcome...

We welcome you to FOR YOUR EYES ONLY Optometric Center. We strive to provide you with the best possible vision care. In order to properly serve you, please print all information. This information is confidential. Thank you for choosing our vision healthcare team !

FOR YOUR EYES ONLY | **Dr. Wayne L. Martin & Associates • 1811 Ygnacio Valley Rd. Walnut Creek, CA • (925) 933-1344**

Patient Information (confidential)

Today's date ____/____/____

Name _____ Birthdate ____ / ____ / _____ Age _____

Address _____ City _____ State _____ ZIP _____

Home phone (____) _____ - _____ Work phone (_____) _____ - _____ Cell phone (_____) _____ - _____

Email _____ You may leave a message at my workplace: ❒ YES ❒ NO Email: ❒ YES ❒ NO

Occupation _____ Sports _____ Hobbies _____

Person responsible for payment _____ Relationship to patient _____

Whom may we thank for referring you? Family/friend name _____ ❒ LOCATION ❒ WEB ❒ YELLOWPAGES ❒ V.I.P.

**** PAYMENT IS DUE WHEN SERVICES ARE RENDERED OR PRESCRIPTION IS ORDERED ****
**** THERE WILL BE A 50% FEE FOR ANY CANCELED/RETURNED/EXCHANGED ORDERS ****

Patient Signature _____

PLEASE INTRODUCE US TO YOUR FAMILY:	AGE:	PATIENT IN OUR OFFICE:	LAST EYE EXAM:
SPOUSE _____	_____	❒ YES ❒ NO	_____
CHILDREN _____	_____	❒ YES ❒ NO	_____
_____	_____	❒ YES ❒ NO	_____
_____	_____	❒ YES ❒ NO	_____

Patient Medical History

What is the main reason for your visit today? _____

Last Vision Exam ___ /___ /___ DR. _____ Address _____ Phone _____

Last Physical Exam ___/___/__ DR. _____ Address _____ Phone _____

Currently wearing glasses? ❒YES ❒NO ***Do you feel you are seeing clearly with your current glasses?*** _____

Currently wearing contacts? ❒YES ❒NO ***How many years?*** _____ ***Age of current lenses*** _____

Are your lenses? Daily wear ❒ Extended wear ❒ Soft ❒ Hard ❒ Disposables ❒ 1-day disposables ❒ Bifocal ❒

Are you experiencing any of the following?

	YES	NO		YES	NO
Eyestrain	❒	❒	Blurred near vision	❒	❒
Headaches	❒	❒	Blurred distance vision	❒	❒
Red Eyes	❒	❒	Computer related eyestrain	❒	❒

Vision related challenges at:

	YES	NO
Work	❒	❒
Sports	❒	❒
Hobby	❒	❒

Other _____

Have you had LASIK? ❒YES ❒NO ***or PRK?*** ❒YES ❒NO ***Date*** ____/____/____ ***Interested in knowing more about LASIK?*** ❒YES ❒NO

Do you or anyone in your family currently have or have had any of the following? If so, who? _____

Eye turn/Lazy eye _____ Cancer _____

Heart disease_____ Cataracts _____

High blood pressure _____ Diabetes _____

Thyroid problems _____ Glaucoma _____

Macular degeneration_____ Other _____

Please list any medications you are taking and what for?

_____

_____

Please list any allergies _____

_____

Alcohol use ❒ Never ❒ Moderate ❒ Heavy

Smoker use ❒ Never ❒ Moderate ❒ Heavy

Drug use ❒ Never ❒ Moderate ❒ Heavy

Have you had cataract surgery? ❒YES ❒NO R/L/Both When ___/___/___ Surgeon_____ Phone_____

*** *** *** *** *** *** FOR OFFICE USE ONLY *** *** *** *** *** ***

Follow up visit date ____/_____/ _____ Dr. Init. _____

_____

_____

_____

Treatment plan _____

_____

_____

Follow up visit date ____/_____/ _____ Dr. Init. _____

_____

_____

_____

Treatment plan _____

_____

_____