Welcome! We strive to provide the best possible vision care.

Your information is kept confidential. We thank you for choosing our vision health care team!

Rosalia Saavedra, OD • Wayne Martin, OD • Michael Rosner, OD
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PATIENT INFORMATION

Check One:
▫ Mr. ▫ Mrs. ▫ Miss ▫ Ms. ▫ Dr. ▫ Minor
Date:_____
Name:_____
Email:_____
Address:_____City:_____ST:_____Zip: _____
Home #:_____ Mobile #:_____
Date of Birth:_____Age:_____ Reason for visit:_____
Is Responsible Party the patient? ▫ Yes ▫ No
_____
Name & Relation to Patient:

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Work Address:
_____
_____
May we contact you at work: ▫ Yes ▫ No Work Phone:

REFERRAL INFORMATION

How did you find out about us? ▫ Insurance list ▫ Walked by ▫ Internet ▫ Doctor_____
▫Existing patient/Name: ▫Other/Explanation:

INSURANCE INFORMATION

Name of Vision Insurance: ▫ VSP ▫ MES ▫ Eyemed ▫ Medicare ▫ Spectera ▫ None ▫ Other_____
SS #:_____
Name of Primary Medical Insurance:_____
_____
Group #:_____ ID #:_____
Name of Primary Member:

MEDICAL HISTORY

1. Do you have any allergies to medications? ▫ No ▫ Yes. If yes, explain:_____
_____
_____

2. List any medication you take (include oral contraceptives, aspirin, over the counter and home remedies):
_____
_____
_____
_____

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

4. Do you or a family member have/had any of the following? Circle "S" for self and/or "F" for family member.

S / F - lazy eye	S / F - drooping eyelid	S / F - cataracts	S / F - retinal disease
S / F - eye injuries	S / F - eye infections	S / F - macular degeneration	S / F - diabetes
S / F - glaucoma	S / F - stroke	S / F - hypertension	S / F - heart problems

Other _____

5. Are you pregnant or nursing? ▫ No ▫ Yes
6. Do you wear glasses? ▫ No ▫ Yes if yes how old is your present pair?
_____
7. Do you wear contact lenses? ▫ No ▫ Yes if yes how old is your present pair?
_____
8. What type of contact lenses? ▫ Rigid ▫ Soft ▫ Extended wear ▫ Other_____
9. Are they comfortable? ▫ No ▫ Yes

SOCIAL HISTORY

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

▫ YES, I would prefer to discuss my Social History information directly with my doctor.

1. Do you drive? ▫ No ▫ Yes If yes, do you have visual difficulty when driving? ▫ No ▫ Yes

Describe difficulty:_____

_____

2. Do you use tobacco products? ▫ No ▫ Yes If yes, type/amount/how long: _____

3. Do you drink alcohol? ▫ No ▫ Yes If yes, type/amount/how long: _____

4. Do you use illegal drugs? ▫ No ▫ Yes If yes, type/amount/how long: _____

5. Have you ever been exposed to or infected with: ▫ Gonorrhea ▫ hepatitis ▫ HIV ▫ Syphilis

REVIEW of SYSTEMS

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

SYSTEMS	NO	YES	?	SYSTEM	NO	YES	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, weight loss/gain	▫	▫	▫	Allergies/Hay fever	▫	▫	▫
Skin	▫	▫	▫	Sinus congestion	▫	▫	▫
Neurological				Runny Nose	▫	▫	▫
Headaches	▫	▫	▫	Post-Nasal Drip	▫	▫	▫
Migraines	▫	▫	▫	Chronic Cough	▫	▫	▫
Seizures	▫	▫	▫	Dry Throat	▫	▫	▫
Eyes				**Respiratory**			
Loss of Vision	▫	▫	▫	Asthma	▫	▫	▫
Blurred Vision	▫	▫	▫	Chronic bronchitis	▫	▫	▫
Distorted Vision	▫	▫	▫	Emphysema	▫	▫	▫
Loss of side vision	▫	▫	▫	**Vascular/cardiovascular**			
Double vision	▫	▫	▫	Diabetes	▫	▫	▫
Dryness ▫		▫	▫	▫ Heart pain		▫	▫
Mucous discharge	▫	▫	▫	High blood pressure	▫	▫	▫
Redness	▫	▫	▫	Vascular disease	▫	▫	▫
Sandy or gritty feeling	▫	▫	▫	**Gastrointestinal**			
Itching	▫	▫	▫	Diarrhea	▫	▫	▫
Burning ▫		▫	▫	▫ Constipation		▫	▫
Foreign body sensation	▫	▫	▫	**Genitourinary**			
Excess tearing	▫	▫	▫	Genitals/kidney/bladder	▫	▫	▫
Glare/light sensitivity	▫	▫	▫	**Bones/joints/muscles**			
Eye pain/soreness	▫	▫	▫	Rheumatoid Arthritis	▫	▫	▫
Chronic infection	▫	▫	▫	Muscle pain	▫	▫	▫

Stye/chalazion	□	□	□	Joint pain	□	□	□
Flashes/floaters in vision	□	□	□	Lymphatic/**hematologic**			
Tired eyes	□	□	□	Anemia	□	□	□
Endocrine				Bleeding problems	□	□	□
Thyroid/other gland	□	□	□	**Allergic/immunologic**	□	□	□
				Psychiatric	□	□	□

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

_____
_____
_____
_____

I understand that if my insurance cannot provide prior guarantee of payment, I will be responsible for all charges incurred at the time of service. I hereby authorize For Your Eyes Only Optometry Center to release information applicable to benefits payable for services.

Signature: _____ Date: _____