Optometry Corner

Hawkin Lui, O.D. / Dan W. Gilbert, O.D. • 4940 Irvine Blvd., Ste 102, Irvine, California 92620 • 714.730.9580

Name _____ Mr. Mrs. Ms. Dr. (circle one)

Address _____

City _____ State _____ Zip _____

Email Address _____

Birth Date _____/_____/_____ Age_____ SS#_____-_____-_____ *(or last 4 digits)*

Guardian/Spouse (if applicable) _____

Date _____/_____/_____

Hm Phone_____

Wk Phone _____

Cell Phone _____

Occupation _____

Employer_____

What is your preferred methd(s) of contact? ☐ Text message ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

Insurance Information

Vision Insurance Plan _____VSP _____EyeMed _____MES _____Other_____

Medical Insurance Plan _____ Secondary Insurance Plan _____

Primary Subscriber's Name _____ *Primary Subscriber's Birth Date* _____/_____/_____

Primary Subscriber's SS# _____-_____-_____ *(or last 4 digits)*

Who may we thank for referring you to our office?

☐ **Healthcare Provider Name** _____ ☐ **Friend/Relative Name** _____

☐ **Yelp** ☐ **Google** ☐ **Insurance Directory** ☐ **Other** _____

What is the purpose of today's visit? _____

Ocular History

Last Eye Exam: ____/_____/____ Previous Eye Doctor _____City & State_____

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____

Do you wear contacts? ☐ No ☐Yes If yes, What type? (please check all that apply)

☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision ☐ Extended Wear ☐ Full Time ☐Part Time

Have you had refractive surgery? ☐ No ☐ Yes If yes, Date _____ Type _____

What other services would you like to be evaluated for? ☐ LASIK or other Refractory Surgery ☐ Contact Lenses
☐ Computer Glasses ☐ Reading Glasses ☐ Sunglasses ☐ Driving Glasses ☐ Other _____

Do you experience any of the following? ☐ Distance Blur ☐ Reading Blur ☐ Eye Strain ☐ Headaches
☐ Dry Eyes (Mild / Moderate / Severe) ☐ Double Vision ☐ Flashers/Floaters ☐ Glare/Light Sensitivity

Are you having other visual difficulties? ☐ No ☐Yes If yes, please explain_____

Do you work on any electronic devices (ie: computer, laptop, ipad, kindle, etc…) ☐ No ☐ Yes

How many hours per day on the average? _____

Medication History List medications and dosages you currently take (including oral contraceptives, aspirin, over-the-counter medications & home remedies):

_____

_____

Please list any ***MEDICATION ALLERGIES:*** _____

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

☐ I prefer to discuss my Social History information directly with the doctor.

Do you (check all that apply):

☐ Use tobacco products ☐ Drink alcohol ☐ Other drugs

Family History

Please note any family history for the following conditions:

	Mother	Father	Grandparents	Siblings	Child(ren)	Self	Additional Comments *(please specify if sibling is brother/sister, and if child is son/daughter)*
Glaucoma	☐	☐	☐	☐	☐	☐	_____
Cataracts	☐	☐	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	☐	☐	_____
Eye Injury	☐	☐	☐	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	☐	☐	☐	_____
Blindness	☐	☐	☐	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	☐	☐	☐	_____
Lazy Eye	☐	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	☐	☐	_____
High Cholesterol	☐	☐	☐	☐	☐	☐	_____

Review of Systems

Have you had any problems in the following areas within the last year? (Check all that apply):

Constitutional
- ☐ Appetite Changes
- ☐ Chronic Fatigue
- ☐ Insomnia
- ☐ Abnormal Weight Loss/Gain

Cardiovascular
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Aneurysms
- ☐ Flutters

Ears, Nose, Mouth, Throat
- ☐ Chronic Sinus Congestion
- ☐ Chronic Colds
- ☐ Chronic Throat Infections
- ☐ Hearing Loss

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

Gastrointestinal
- ☐ Chronic Diarrhea
- ☐ Chronic Constipation
- ☐ Hemorrhoids

Genitourinary
- ☐ Bladder Infections
- ☐ Kidney Stones
- ☐ Sexually Transmitted Diseases

Musculoskeletal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

Integumentary
- ☐ Rashes
- ☐ Chronic Bruising
- ☐ Dermatitis
- ☐ Eczema
- ☐ Skin Cancer

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures/Epilepsy

Psychiatric
- ☐ Mood Swings
- ☐ Depression

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Excessive Bleeding

Allergic/Immunologic
- ☐ General Allergic Disorders
- ☐ HIV/AIDS
- ☐ Leukemia

Women - Are you pregnant and/or nursing?
___YES ___NO

If you answered yes to any of the above, or have a condition not listed, please elaborate:

_____

_____

How would you like to be notified for your yearly eye exam? ☐ Postcard ☐ E-mail ☐ Phone Call ☐ Text Message

Signature_____Date_____