PASADENA EYECARE

Welcome to Pasadena Eyecare. In order to provide you with the best care, please complete the following information. Our staff will be glad to assist if you have any questions.

Today's Date: _____/______/_____

Name: ___________________________ Date of Birth: _____________ Age:____________________

Current Address:____

City, State Zip _________________________ If Child (Guardian Name) _________________________

Email address: ______________________________ SSN# _____________________________________

Home Phone: ________________Wk Ph: _________________ Cell Ph: ________________________

Occupation: ___________________________ Married [ ] Partnered [ ] Single [ ] Student [ ]

Who may we thank for referring you to our office?____

Patient History Information

During your visit today please circle if you would like a prescription for: Glasses Contact lenses

Have you worn glasses? Yes [ ] No [ ] If so, how old are your current glasses? ______yrs.

Have you worn contact lenses? Yes [ ] No [ ] If so, how old are your contacts? ____. Type of contacts?________

To provide you with the best care possible, we need the following information:

Medications:

Please list any medications you are taking and what they are for: ____

____

____

Please list any allergies to medications you are aware of:

____

Who is your medical doctor? __________________________________ Date of last exam: _____________________

Who was your last optometrist? ______________________________ Date of last eye exam:___________________

Medical Information: Please place a **check** in the blank if the described condition applies to you.

Allergies

Do you have seasonal allergies? ____

Itchy eyes? ____

Chronic sinus infections? ____

Medical Health

Do you have high blood pressure? ____

A history of stroke? ____

Diabetes? ____

High cholesterol? ____

Asthma or lung problems? ____

Arthritis ____

Thyroid condition? ____

HIV or AIDS? ____

Family History

Glaucoma? ____

Diabetes? ____

Loss of Vision? ____

Macular Degeneration? ____

High Blood Pressure? ____

Neurological ____

Do you have frequent headaches? ____

Migraines? ____

Ocular Muscles

Do you have strabismus (turned eye)? ____

Prism in your glasses? ____

Did you ever have vision therapy? ____

Do you ever see double? ____

Ocular Health?

Do you have glaucoma? ____

Do you have amblyopia (lazy eye)? ____

A history of ocular trauma ____

Watery /Burning eyes? ____

Cataracts? ____

A history of an eye surgery? ____

Floaters? ____

Have you ever had a retinal detachment? ____

Macular degeneration? ____

Gritty or Sandy Feeling in the eyes? ____

Optical

Do you have problems with glare? ____

Work on a computer? ____

Participate in sports? ____

Blurred vision with current glasses ____

Are you interested in LASIK? ____

Have you ever had head trauma? ____

Is there any additional information about your **visual** or **medical** health we should know about you?

If so, please explain here: ____

____