ANTELOPE VALLEY FAMILY OPTOMETRY
Commitment to eyecare excellence since 1988

PATIENT INFORMATION SHEET *Adult 18+*

Date:_____

Thank you for entrusting the health of your eyes to us. Our commitment is to provide you the highest standards in eyecare.
To help us serve you best, please answer the questions below, so we can offer you a customized plan for your contacts or glasses.

PATIENT'S NAME (Last, First, Middle)	How did you hear about us? □ Insurance □ Friend, who?
MAILING ADDRESS / P.O. BOX	BIRTHDATE (m/d/y) / / SEX □ Male □ Female
CITY STATE ZIP HOME PHONE	SOCIAL SECURITY # - - DL# STATE
WORK PHONE HOME PHONE CELL PHONE	EMPLOYED BY OCCUPATION
SPOUSE'S NAME & SOCIAL SECURITY #	EMAIL You prefer we notify you via email? Or cell phone via text? □ Yes / No □ Yes / No

PERSONAL EYE HISTORY Check all that apply

□ Blurred Vision
□ Far-away
□ Up-close
□ At night
□ Burning
□ Dryness
□ Itchy
□ Red
□ Eye Pain
□ Halo's
□ Floaters
□ Light Sensitivity
□ Eyestrain
□ Headaches: location_____
□ Other:

Have you ever worn contacts? □ Yes □ No

Interested in Contact Lenses? □ Yes □ No

If new to contacts, interested in a free contact lens test drive? □ Yes □ No

Are you interested in LASIK? □ Yes □ No

Do you drive a vehicle? □ Yes □ No

About how many hours on computer per day? _____ Hr.

PERSONAL MEDICAL HISTORY Check all that apply

Personal Physician:_____

The last time you saw your doctor was? _____

□ Cardiovascular (high BP, pulse, heart disease)
□ Ears/Nose/Throat (hearing, cough)
□ Respiratory (congestion, wheezing)
□ Gastrointestinal (ulcer, diarrhea, constipation, hernia)
□ Musculoskeletal (muscle, arthritis/joint, bone)
□ Endocrine (thyroid, diabetes, gland)
□ Neurological (brain, nerve, spinal cord)
□ Psychiatric
□ Hematologic (cancer, high cholesterol, blood)
□ Allergy/Immunology (allergies, hay fever)
□ Integumentary (skin)
□ Blood / Lympth (bleeding, anemia, cholesteremia)
□ Other_____

What are some of your hobbies, interests?

List any prescription and/or non-prescription medications you take: (If you have a list, please allow us to make a copy)

List any Major Illnesses, Injuries, or Surgeries with approximate dates:

Do any family members (**M**other, **F**ather, maternal or paternal grandparents **MGP PGP**, **B**rother, **S**ister, **S**on, **D**aughter) have the following? Please note relationship below.

□ Blindness □ Lupus □ Heart Disease
□ Cataract □ Arthritis □ Kidney Disease
□ Crossed Eyes □ Cancer □ Thyroid Disease
□ Glaucoma □ Diabetes
□ Macular Degeneration □ High blood pressure
□ Retinal Disease □ Other_____

SOCIAL HISTORY Check all that apply

Do you use tobacco products? □ Yes □ No
Do you drink alcohol? □ Yes □ No
Do you take illegal drugs? □ Yes □ No
Are you pregnant or nursing? □ Yes □ No
Have you been exposed to or infected with:
□ HIV □ Hepatitis A B C □ Syphilis □ Gonorrhea □ TB

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I received a copy of Drs. Lin and Quach, O.D.'s Notice of Privacy Practices.

SIGNATURE:_____ Date:_____
If minor under 18 years old, signature of parent or legal guardian

All fees are due at the time service is rendered. We'll be happy to assist you in completing your insurance forms however, the patient is responsible for all fees incurred. I authorize release of info to all my Insurance Companies.

SIGNATURE:_____ Date:_____
If minor under 18 years old, signature of parent or legal guardian NEW REVIEWED DATE: /