ReVision OPTOMETRY

2020 Camino Del Rio N., Ste 109
San Diego CA 92018

Tel: (619) 299-6064
Fax: (619) 298-6064

Please fill out all pages clearly and completely

PERSONAL DEMOGRAPHICS

Title: _____ **First:** _____ **Middle:** _____ **Last:** _____ **Suffix:** _____ **Nickname:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Home Phone: (_____)_____-_____ **Mobile:** (_____)_____-_____ **Work Phone:** (_____)_____-_____ **Ext:** ____

DOB: _____ **Sex:** _____ **SSN:** _____ **Pref. Contact:** _____ **Email:** _____

Date Of Appointment: _____ **Pref. Language:** _____ **Marital Status:** _____

Employment Status: _____ **Occupation**: _____ **Employer:** _____

Have any family members been previously examined by Dr. Chou? ○ Yes ○ No ○ Not Sure

If yes, who in the family? _____

Employer Name (or School): _____ **Position (or Grade):** _____

How did you first find out about us? ○ Family, Friend, or Co-Worker ○ Doctor referral ○ Eye care plan directory

○ Print advertisement ○ Internet (What website? _____) ○ Other: _____

PAYMENT INFORMATION

Are you a member of an eye care plan? ○ Yes If yes, please mark your plan(s) below. ○ No, I will be paying out of pocket.

○ Vision Service Plan (VSP) ○ EyeMed ○ Medical Eye Services (MES)

Insured Party: ○ Self ○ Other (please indicate below) **Relation to Insured:** _____

First: _____ **Last:** _____ **DOB:** _____ **Last four of SSN:** _____ **Member ID:** _____

OCULAR HISTORY

Reason(s) for your visit today? ○ Glasses ○ Contact Lenses ○ Laser Vision Correction ○ Eye health evaluation

○ Keratoconus ○ School Referral ○ Concern over DMV eye test ○ Other: _____

When was your last comprehensive eye examination? ○ Never ○ Less than 1 year ○ 1 year ○ 2 years ○ 3+ years

Describe your computer use: ○ Extensive (5+ hrs/day) ○ Moderate (2-5 hrs/day) ○ Low (less than 2 hrs/day)

OCULAR HISTORY CONTINUATION

Eye surgeries: ○ None ○ LASIK ○ PRK ○ RK ○ Cataract ○ Retinal ○ Glaucoma ○ Eyelid

○ Other: _____

Eye conditions: ○ Cataract ○ Glaucoma ○ Macular Degeneration ○ Keratoconus ○ Other: _____

Which statement applies to you? ○ I've never worn contacts (skip rest of section). ○ I wear contacts daily.

○ I wear contacts occasionally. ○ I used to wear contacts.

If you wear contacts, do you sleep with them regularly? ○ Yes ○ No

If yes, how many nights in a row will you wear them without removal? _____

Are your contacts (check all that apply)**:** ○ Soft ○ Rigid ○ Hybrid (SynergEyes) ○ Sclerals ○ Other: _____

If *soft disposable*, which brand and lens power are you wearing (if known): _____

How old is the pair you are currently wearing? _____ **How frequently do you replace a pair?** _____

FAMILY OCULAR HISTORY

Please indicate if any of your blood relatives have the following:

Cataracts ○ Yes (Please Specify: _____) ○ No ○ Unsure

Diabetic Retinopathy ○ Yes (Please Specify: _____) ○ No ○ Unsure

Glaucoma ○ Yes (Please Specify: _____) ○ No ○ Unsure

Macular Degeneration ○ Yes (Please Specify: _____) ○ No ○ Unsure

Other eye disease (Please Specify)**:** _____

PERSONAL MEDICAL HISTORY

Do you take any prescription or non-prescription medicines regularly? ○ Yes ○ No

_____

_____

_____

Any Allergies to Medicine? ○ None known ○ Penicillin ○ Sulfa drugs ○ Codeine ○ Other: _____

PERSONAL MEDICAL HISTORY CONTINUATION

Any significant conditions of the following medical systems?	(Please mark)	If yes, please specify:
General constitution (fibromyalgia, obesity, anorexia, bulimia)	○ Yes ○ No	_____
Ear / nose / throat (hearing loss, sleep apnea)	○ Yes ○ No	_____
Neurologic (migraine headaches, traumatic brain injury)	○ Yes ○ No	_____
Psychiatric (depression, memory loss, OCD)	○ Yes ○ No	_____
Cardiovascular (high blood pressure, cholesterol, stroke, heart)	○ Yes ○ No	_____
Respiratory (asthma, tuberculosis)	○ Yes ○ No	_____
Gastrointestinal (inflammatory bowel disease, Crohn's disease)	○ Yes ○ No	_____
Genitourinary (kidney failure, prostate/ovarian cancer, pregnant	○ Yes ○ No	_____
Muscle / joints (Marfan's syndrome, rheumatoid arthritis)	○ Yes ○ No	_____
Skin (eczema, acne rosacea)	○ Yes ○ No	_____
Endocrine (diabetes mellitus, hypo- or hyper-thyroid)	○ Yes ○ No	_____
Blood (anemia, blood clotting disorders, sickle cell)	○ Yes ○ No	_____
Allergic / Immunologic (hayfever, HIV, lupus)	○ Yes ○ No	_____

AVOCATION

So that we understand your vision needs, are there any hobbies or sports that you enjoy?

PRIVACY PRACTICES ACKNOWLEDGEMENT AND 3RD PARTY PAYMENT AUTHORIZATION

I acknowledge that I have received the the ReVision Optometry's Notice of Privacy Practives, available from our office receptionist. You can also review it on our website, www.ReVisionOptometry.com. Additionally, I authorize the payment of any eye care benefits or medical insurance to ReVision Optometry. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred.

Signature of patient (or parent/guardian for minors) ***/S/*** _____