



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: _____ Last four of SSN: _____ Email: _____

Marital Status: _____ Pref. Contact: _____ Pref. Language: _____

Employment Status: _____ Occupation: _____ Employer: _____

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

If yes, who in the family? _____

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: _____

VOCATION & AVOCATION

So that we understand your vision needs, please describe your work, school, and/or any hobbies you enjoy.

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) Relation to Insured: _____ Member ID: _____

First: _____ Last: _____ DOB: _____ Last four of SSN: _____

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 digital device use: Extensive (5+ hrs/day) Moderate (2-5 hrs/day) Low (less than 2 hrs/day)

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) Scleral Other: _____

If soft disposable, which brand and lens power are you wearing?

Right eye: Brand: _____ Base Curve: _____ Power: _____

Left eye: Brand: _____ Base Curve: _____ Power: _____

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? If yes, please list below. o Yes o No

Any allergies to medicine? o None known o Penicillin o Sulfa drugs o Codeine o Other: _____

Any significant conditions of the following medical systems? (Please mark) If yes, please specify/circle:

General constitution (fibromyalgia, obesity, anorexia, bulimia) o Yes o No _____

Ear / nose / throat (hearing loss, sleep apnea) o Yes o No _____

Neurologic (migraine headaches, traumatic brain injury) o Yes o No _____

Psychiatric (depression, memory loss, OCD) o Yes o No _____

Cardiovascular (high blood pressure, cholesterol, stroke) o Yes o No _____

Respiratory (asthma, tuberculosis) o Yes o No _____

Gastrointestinal (inflammatory bowel disease, Crohn's disease) o Yes o No _____

Genitourinary (kidney failure, prostate/ovarian cancer, pregnant) o Yes o No _____

Muscle / joints (Marfan's syndrome, rheumatoid arthritis) o Yes o No _____

Skin (eczema, acne, rosacea) o Yes o No _____

Endocrine (diabetes mellitus, hypo- or hyper- thyroid) o Yes o No _____

Blood (anemia, blood clotting disorders, sickle cell disease) o Yes o No _____

Allergic / Immunologic (hay fever, HIV, lupus) o Yes o No _____

PRIVACY PRACTICES ACKNOWLEDGEMENT AND 3RD PARTY PAYMENT AUTHORIZATION

I acknowledge that I have received ReVision Optometry's Notice of Privacy Practices, available at https://revisionoptometry.com/privacy. 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 (Typing your name suffices as your electronic signature)

/S/ _____