ReVision OPTOMETRY

2020 Camino Del Rio N., Ste 109
San Diego CA 92108

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

○ AI Assistant (e.g., ChatGPT, Gemini, Claude) ○ 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 pay out-of-pocket.

○ Vision Service Plan (VSP) ○ EyeMed

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
○ Corneal Cross-Linking ○ Other: _____

Which eye(s) underwent surgery? ○ Right Eye (OD) ○ Left Eye (OS) ○ Both Eyes (OU)

Date of Surgery: _____

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. ○ Yes ○ No

_____

_____

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

_____

Any *significant* conditions of the following medical systems?	**(Please mark)**	**If yes, please specify/circle:**
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)	○ 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 disease)	○ Yes ○ No	_____
Allergic / Immunologic (hay fever, HIV, lupus)	○ Yes ○ 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/_____