WELCOME TO OUR OFFICE

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT INFORMATION

Todays Date:_____

Last_____

First_____MI_____
Street_____
City_____State_____
Zip_____ Patient's Date of Birth; _____
Sex Female ☐ Male ☐ Age: _____
Home Phone:_____
Work Phone: _____
Cell Phone: _____
Email Address: _____
May we communicate by:
Text ☐ Email ☐ Phone ☐
All of the above ☐
Patient's SSN_____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name)_____
Spouse (or Parent's Work) _____

Any problems with your current contact lenses or glasses?

_____

_____

Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?
☐ Another Doctor
☐ Insurance Listing
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Yellow Pages
☐ Web Page

INSURANCE INFORMATION

Please note that insurance does NOT cover Contact Lens Follow-up Evaluation

Vision Insurance _____
Subscriber Name:_____
Subscriber Birth Date:_____

Primary Medical Insurance:_____
Subscriber Name: _____
Subscriber Birth Date:_____
Do you participate in a flex spending account?
Yes ☐ No ☐
How will you settle your account today?
Cash ☐ Check ☐ Credit Card ☐

PAYMENT IS DUE AT TIME OF SERVICE

Computer Use

Hours per day you use a computer _____
Is your computer screen: Above Eye Level _____
At Eye Level _____
Below Eye Level _____
Irritated/Burning/Watery/Sore (circle which apply)
Headaches during or after computer use?
____yes___no
Bother some Glare/Reflection on Screen?
____ yes __no
Double vision or letters on screen run together
____yes___no
Do you have blurry vision after using the computer?
___yes___no

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision	☐ Iritis/Uveitis
☐ Burning	☐ Itchiness
☐ Cataracts	☐ Lazy Eye
☐ Corneal Abrasion	☐ Macular degeneration
☐ Double Vision	☐ Occasional Dryness
☐ Eye Infections	☐ Retinal Detachment
☐ Eye Injury	☐ Sunlight Sensitivity
☐ Flash of Light	☐ Tearing
☐ Floaters/Spots	☐ Trouble seeing at night
☐ Glaucoma	☐ Other
☐ Grittiness	
☐ Allergies	☐ Genitourinary
☐ Arthritis	☐ Headache
☐ Asthma	☐ Heart Disease
☐ Autoimmune Disease	☐ High Blood Pressure
☐ Blood/Lymph	☐ Integumentary – Skin
☐ Cancer	☐ Kidney
☐ Cholesterol	☐ Muscle/Bone
☐ Diabetes	☐ Neurological
☐ Digestive	☐ Psychological _____
☐ Ears/Nose/Throat	☐ Sleep Apnea
☐ Eczema/Rashes	☐ Sinus
☐ Endocrine	☐ Thyroid
☐ Fatigue	☐ Unusual weight loss/gain

☐ Other_____

FAMILY MEDICAL/EYE HISTORY (Check all that apply)

Is there a family medical history of any of the following?

	Relationship
Blindness	☐ _____
Cataracts	☐ _____
Corneal Problems	☐ _____
Diabetes	☐ _____
Glaucoma	☐ _____
Heart Disease	☐ _____
Lazy Eye	☐ _____
Macular Degeneration	☐ _____
Retinal Problems	☐ _____
Other Eye Disease	☐ _____

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications? ☐ Yes ☐ No
If so, what
medications?_____
_____
_____
_____
_____

Please list all surgeries you have had.

_____
_____
_____
_____
_____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

_____
_____

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Fax: 925-634-0338
www.deltavistaeye.com

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Have you ever tried contact lenses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes☐ No

What kind?
_____
Solution used?
_____

Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Would you prefer clear contact lenses or colored contact lenses? ☐ Clear ☐ Colored

If you wear bifocals, do the lines or head tilting bother you? ☐ Yes ☐ No

To avoid a $50.00 cancellation fee –
Kindly give us a 24 hour notice!

I hereby authorize **Delta Vista Optometry Associates** to release any information acquired in the course of my examination or treatment for the purpose of insurance billing and agree to have insurance payment sent directly to this office for services rendered. I further agree that I will be responsible for any unpaid portion, copays, co-ins including insurance deductibles, that may have not been met at the time of service.

PLEASE NOTE THAT A FEE WILL BE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE. THANK YOU.

_____ _____
Signature Date