Dr. Julie Ngo, O.D. Dr. Christopher Campaña, O.D.

Welcome to Our Practice

Today's Date _____

Last _____ First _____ MI_____

Address _____

City_____ State _____ Zip Code _____

Date of Birth _____ Age _____ Sex M F

Home Phone _____ Cell Phone _____

Email Address _____

Marital Status _____ Primary Language_____

Race _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Who may we thank for referring you to our office?

_____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or eyeglass prescription?

_____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID# / Group# _____

Subscriber Birth Date _____

How will you settle your account today?

☐Cash ☐Debit Card ☐Credit Card

Family Medical/Eye History (check all that apply)

Is there a family history of any of the following? (M,F,B,S)

	Relationship
Cataracts	☐_____
Corneal Problems	☐_____
Glaucoma	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____
Cancer	☐_____
Diabetes	☐_____
High Blood Pressure	☐_____

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

The Patient Medical History

Name of Family Physician _____

City _____

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

_____

Have you ever been diagnosed or treated for the following?

☐ Allergies	☐ Diabetes	☐ Thyroid
☐ Asthma	☐ Heart Disease	☐ Other
☐ Arthritis	☐ High Blood Pressure	_____
☐ Cancer	☐ Kidney	_____
☐ Cholesterol	☐ Nerve	☐ ***No health problems***

Are you Pregnant/Nursing ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No ____packs/day

Do you consume alcohol? ☐ Yes ☐ No mild/mod/heavy

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? ☐Yes ☐No

If so, What kind? _____

Solutions Used _____

Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____

Do you…(Check box if your answer is yes)

☐ …Drive?

☐ …Work on a computer?

☐ …Spend time outdoors? (how much?) _____ hrs/week

Have you ever been diagnosed or treated for the following?

☐ Cataracts	☐Iritis/Uveitis
☐ Corneal Abrasion	☐Lazy Eye
☐ Eye Infection	☐Macular Degeneration
☐ Glaucoma	☐Eye Surgery (including LASIK)
☐ Eye Injury	☐Other eye disorders

Are you currently experiecing...

☐ Blurry Vision	☐ Flash Of Light	☐ Sunlight Sensitivity
☐ Burning	☐ Floater/Spots	☐ Crossed Eye/Eye Turn
☐ Tearing	☐ Grittiness	☐ Trouble seeing at night
☐ Headaches	☐ Itchiness	☐ Uncomfortable Glasses
☐ Double Vision	☐ Occasional Dryness	

⇨ OVER