Bay Vision

Name: _____

Address: _____

City, State, Zip: _____

Social Sec. # _____/_____/_____

Date of Birth _____/_____/_____ Age _____

Primary Care Physician _____

Last Medical Exam: _____/_____/_____

Last Eye Doctor: _____

Last Eye Exam: _____/_____/_____

Email Address: _____

Ethnicity: ☐Hispanic/Latino

☐Native Hawaiian/Other Pacific Island

☐Not Hispanic/ Latino

Today's Date: _____/_____/_____

Daytime Phone _____

Work Phone _____

Cell Phone _____

Marital Status: M S D W

Occupation: _____

Employer: _____

Primary Insured's Name: _____

Primary Insured's Social Sec. _____

Pref. method of Contact: ☐Text ☐Email ☐Phone

Race: ☐Native American/ Native Alaskan

☐Asian ☐White ☐Black/African American

☐Native Hawaiian/Other Pacific Island

Have you ever worn glasses? ☐No ☐Yes If yes how old are your current glasses? _____

Do you currently wear contact lenses? ☐No ☐Yes Type of contact lenses: ☐Disposables ☐Gas Perm ☐Soft ☐Bifocal ☐Other

Have you ever had Lasik or Refractive surgery? ☐No ☐Yes If yes, date: _____/_____/_____

Have you ever had eye surgery? ☐No ☐Yes If yes, describe: _____

Check any of the following that **You** have had: ☐Serious eye infection

☐Crossed eyes ☐Lazy eye ☐Drooping eyelid ☐Prominent eyes ☐Glaucoma ☐Retinal disease ☐Cataracts ☐Eye injury

How many hours a day do you work on a computer? _____

Reason for visit:

☐Routine annual exam ☐Need new glasses ☐Contact lenses ☐Lost or broken glasses ☐Interested in Lasik or Laser vision correction

Do you have any specific questions or problems you would like to discuss with your doctor? If yes, please explain: _____

_____

Are you allergic to any medications? ☐No ☐Yes If yes, please explain: _____

Please list any medications you are currently taking: _____

_____ Are you pregnant or nursing? ☐No ☐Yes

Do you currently, or have you ever had any serious problems in the following areas:

Diabetes ☐No ☐Yes **Blood** ☐No ☐Yes **High Blood Pressure** ☐No ☐Yes **Endocrine (Thyroid)** ☐No ☐Yes

Neurological (Headaches) ☐No ☐Yes **Ears, Nose, Mouth, Throat (Allergies)** ☐No ☐Yes **Cholesterol** ☐No ☐Yes

Respiratory ☐No ☐Yes **Eyes** ☐No ☐Yes **Cancer** ☐No ☐Yes **Cardio vascular** ☐No ☐Yes **Skin** ☐No ☐Yes

Gastrointestinal ☐No ☐Yes **Muscular/Skeletal** ☐No ☐Yes **Allergies/Immune** ☐No ☐Yes **Mental** ☐No ☐Yes

Genitourinary ☐No ☐Yes **Other** ☐No ☐Yes

Please note any family history (parents, grandparents, sibling, children: living or deceased) for the following conditions:

Disease/Condition	No	Yes	Relationship to you	Disease/Condition	No	Yes	Relationship to you
Glaucoma	☐	☐	_____	Diabetes	☐	☐	_____
Macular Degeneration	☐	☐	_____	High Blood Pressure	☐	☐	_____
Cataract	☐	☐	_____	Crossed eyes	☐	☐	_____
Retinal Detachment	☐	☐	_____	Blindness	☐	☐	_____
Arthritis	☐	☐	_____	Cancer	☐	☐	_____
Heart Disease	☐	☐	_____	Kidney Disease	☐	☐	_____
Lupus Disease	☐	☐	_____	Thyroid Disease	☐	☐	_____

I acknowledge that I have been made aware of the HIPPA Notice of Privacy Practices.

Patient Name _____ **Signature** _____ **Date** _____