GRIFFIN OPTOMETRIC GROUP

San Clemente ¤ Laguna Niguel ¤ The Courtyards at Talega

We welcome you to our offices. The following vision and health information is requested to help us give you a complete and thorough vision exam. All information is kept private.

Name: _____ Today's Date: ____/____/____

Nickname: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ Preferred Phone: _____

Email : _____ Guardian (If applicable): _____

Birth Date: ___/___/_____ Occupation: _____ Last Eye Exam: _____/____/____

Do you have Vision Insurance: (circle one) VSP Eyemed Other _____

Primary Insured's Info: Name: _____ Last 4 SS#_____ Date of Birth __/____/____

Name of Medical Doctor: _____ Last Medical Exam: __/____/____

Medical Insurance: □ PPO □ HMO □ POS □ None Insurance Company: _____

What is the purpose of today's visit? _____

_____

Are you experiencing any of the following: □ Distance Blur □ Reading Blur □ Eyestrain

Do you work at a computer for long periods? □ yes □ no Do you have prescription sunglasses? □ yes □ no

Do you have problems w/nighttime glare? □ yes □ no Are you interested in contacts? □ yes □ no

Do you have dry, burning or stinging eyes? □ yes □ no Would you like information on LASIK? □ yes □ no

How did you hear about us? Friend/Relative/Another Healthcare Practitioner Who? _____

MEDICAL HISTORY

Height _____ Weight _____

Do you have any allergies to medications? □ yes □ no If yes, please explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, antidepressants, over the counter medications , vitamin supplements): _____

_____

List all major injuries, surgeries and /or hospitalizations you have had in the past year: _____

_____

Please check any of the following that you have had: □ glaucoma □ cataracts □ retinal disease/detachment □ eye infections □ eye injury □ crossed eyes □ drooping eyelid □ lazy eye □ arthritis □ macular degeneration

Are you pregnant and/or nursing? □ yes □ no

Do you wear glasses? □ yes □ no If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? □ yes □ no If yes, how old is your present pair of lenses? _____

Type of contact lenses? □ Rigid □ Soft □ Extended Wear □ Other Are they comfortable? □ yes □ no

FAMILY HISTORY

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

DISEASE/CONDITIONS	YES	NO	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Arthritis	□	□	□	_____

Please turn this form over and complete side two

FAMILY HISTORY (continued)

DISEASE/CONDITIONS	YES	NO	?	RELATIONSHIP TO YOU
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

SOCIAL HISTORY *All information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History directly with my doctor. (check box)

Do you drive? ☐ yes ☐ no If yes, do you have visual difficulty when driving? ☐ yes ☐ no If yes, please describe:

_____

Do you use tobacco products? ☐ yes ☐ no If yes, type/amount/how long? _____
Do you drink alcohol? ☐ yes ☐ no If yes, type/amount/how long? _____
Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long? _____

REVIEW OF SYSTEMS

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

SYSTEM	YES	NO	?
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Distance Blur	☐	☐	☐
Reading Blur	☐	☐	☐
Eyestrain	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Corneal Abrasion	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Tired Eyes	☐	☐	☐

	YES	NO	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCUALAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____

I hereby authorize the release of any medical information necessary to notify my family physician and/or process an insurance claim. I understand I am responsible for any charges not covered by my insurance .

_____ _____ _____

Patient Signature Print Name Date