

WELCOME TO OUR OFFICE

Elk Grove Optometry

A PROFESSIONAL CORPORATION

David T. Kageyama, O.D. Janice H. Tamai, O.D.

Name _____

Today's Date _____ Date of Last Exam _____

Street _____

Where was your last exam? _____

City _____ State _____ Zip _____

Social Security Number _____

Home Phone _____

Date of Birth _____ Age _____ Sex: M F

Cell Phone _____

Vision Insurance:

VSP EyeMed Medical Eye Services Superior

Work Phone _____

Email _____

Employer (or School) _____

Occupation (or Grade) _____

Preferred Method of Contact: Phone Email Text

Spouse (or Parent's Name) _____

Spouse (or Parent's Phone) _____

MEDICAL HISTORY

(circle all that apply)

Allergies	Arthritis
Asthma	Cancer
Skin Disorder	Diabetes
Eye Disease	Heart Disease
Eye Injury	High Blood Pressure
Eye Surgery	Cancer
Lazy Eye	Cataract
Glaucoma	Pregnant and or Nursing
Other _____	

Do You...

..Work at a computer or use handheld electronic devices for long periods?	Y	N
..Have more than one pair of glasses?	Y	N
..Wear bifocals? (if yes, are you bothered by head tilting, restricted areas of vision correction, etc.)	Y	N
..Spend time outdoors? (how much?)	Y	N
..Have prescription sunglasses?	Y	N
..Smoke?	Y	N
..Consume alcohol?	Y	N

CURRENT MEDICATIONS (Rx or Over the Counter)

Name of Medication

Antihistamines	N	Y	_____
Diuretics (water pill)	N	Y	_____
Blood Pressure	N	Y	_____
Eye Drops	N	Y	_____
Oral Contraceptive	N	Y	_____
Thyroid	N	Y	_____
Other _____			

Any know medication allergies? _____

Primary Care Physician _____

FAMILY MEDICAL HISTORY

Relationship

Blindness	N	Y	_____
Cataracts	N	Y	_____
Glaucoma	N	Y	_____
Diabetes	N	Y	_____
Heart Disease	N	Y	_____
Other _____			

Do you experience...

<input type="checkbox"/> Burning	<input type="checkbox"/> Spots	<input type="checkbox"/> Uncomfortable glasses
<input type="checkbox"/> Itching	<input type="checkbox"/> Soreness	<input type="checkbox"/> Sudden loss of vision
<input type="checkbox"/> Nausea	<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Sensitivity to light
<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fainting or dizziness
<input type="checkbox"/> Tearing	<input type="checkbox"/> Redness	<input type="checkbox"/> Blurry distance vision
<input type="checkbox"/> Dryness	<input type="checkbox"/> Double vision	<input type="checkbox"/> Blurry near vision
<input type="checkbox"/> Eye strain		<input type="checkbox"/> Gritty feeling eyes
<input type="checkbox"/> Reading problems		<input type="checkbox"/> Objects floating in vision
<input type="checkbox"/> Glare or reflection		<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Uncomfortable contact lenses		<input type="checkbox"/> Trouble reading or learning at work,
<input type="checkbox"/> Trouble working up-close		school or other activities
<input type="checkbox"/> Other _____		

How did you first hear about our office?

Friend or Relative Who? _____

Insurance Plan

Another health care practitioner Who? _____

Internet (ex. Google or Yelp) _____

Other _____

Payment is due when services are rendered. A 50% deposit is required upon ordering glasses or contact lenses.

