WELCOME TO OUR OFFICE

Elk Grove Optometry

A PROFESSIONAL CORPORATION

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

Name _____

Street _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Phone) _____

Today's Date _____ Date of Last Exam _____

Where was your last exam? _____

_____

Social Security Number _____

Date of Birth _____ Age _____ Sex: M F

Vision Insurance:

□ VSP □ EyeMed □ Medical Eye Services □ Superior

Email _____

Preferred Method of Contact: □ Phone □ Email □ Text

MEDICAL HISTORY

(circle all that apply)

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

Other _____

_____

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...

..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?	Y	N
(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

Do you experience...

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