MILL VALLEY OPTOMETRY

61 Camino Alto, Suite 100A, Mill Valley, CA 94941
415.381.2020

Date _____ Email _____

Name _____ Sex: M___ F___ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Responsible Party: _____ SS # _____

Telephones: Home # _____ Wk. # _____ Cell # _____

Employer: _____ Occupation: _____

Medical Insurance: _____

Subscriber Name _____ SS # _____ DOB _____

Vision insurance: _____

Subscriber Name _____ SS # _____ DOB _____

Please list other people living in your home: _____

Name _____ Relationship _____ Age _____

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Name _____ Relationship _____ Age _____

Date of last eye exam: _____ Name of Doctor: _____

Do you wear glasses? _____ How many hours a day do you spend at a computer? _____

Do you wear contact lenses? _____ Do you wear Sunglasses? _____

Who referred you to this office? _____

What is the reason for today's visit? _____

ADULT EYE HEALTH HISTORY

OCULAR HISTORY

Do you experience any of the following?
Please check if YES.

- ☐ Blurry vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye strain
- ☐ Redness
- ☐ Dryness
- ☐ Headaches/migraines
- ☐ Burning/itching
- ☐ Light sensitivity
- ☐ Flashes/floaters
- ☐ Dizziness/Balance issues

Do you have a history of?

- ☐ Cataracts
- ☐ Crossed eye/lazy eye
- ☐ Amblyopia
- ☐ Glaucoma
- ☐ Macular problems
- ☐ Retinal Detachment
- ☐ Eye Injury
- ☐ Ear infections
- ☐ Eye surgery
- ☐ Head injury
- ☐ Eye disease

MEDICAL HISTORY

Date of last medical exam: _____

Doctors name: _____

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List all medications you are currently taking and why?

_____ _____

_____ _____

_____ _____

_____ _____

Do you currently have any of the following problems?

- ☐ Sinus, ears, nose
- ☐ Respiratory (lungs, breathing, TB)
- ☐ Cardiovascular (heart, blood pressure)
- ☐ Stomach, colon
- ☐ Neurologic (seizures)
- ☐ Bones, joints, arthritis
- ☐ Thyroid
- ☐ Fatigue
- ☐ Diabetes
- ☐ Allergies

Please list all allergies including to drugs.

_____

_____

_____

_____