Point Richmond Optometry

Last Name: _____

First Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____

Referred By: _____

Sex: M F Date of Birth: _____

Social Security Number: _____

Marital Status: _____

Employment Status: _____

Employer: _____ Occupation: _____

Preferred Language: _____

Race:

- Native American/Native Alaskan ☐
- Asian ☐
- Black/Africian American ☐
- Hispanic ☐
- Native Hawaiian/Other Pacific Island ☐
- White ☐

Ethnicity:

- Hispanic/Latino ☐
- Native Hawaiian/Other Pacific Island ☐
- Not Hispanic/Latino ☐

Communication Preferred: Email Telephone Postal

Last Eye Exam: _____ Doctor: _____

# PATIENT HEALTH HISTORY

**Patient Name:** _____ **DOB**: _____ **Primary Care Physician:**_____ **City**:_____

| | | Yes | No |
|---|---|---|---|
| **Do You Wear:** | **Clear Glasses?** | ☐ | ☐ |
| | **Rx Sunglasses?** | ☐ | ☐ |
| | **Computer Glasses?** | ☐ | ☐ |
| | **Contact Lenses?** | ☐ | ☐ |

**Whom may we thank for referring you?** _____

| | Yes | No |
|---|---|---|
| **May we contact you electronically?** | ☐ | ☐ |

Email address: _____

**Medical/Family History (use back sheet if more space is needed)**

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to medications or eye drops: _____

_____

**Please indicate if any of the conditions apply to you or a family member (blood relatives only).**

| **Disease/Condition** | **Yourself** Yes | No |
|---|---|---|
| Cataract | ☐ | ☐ |
| Eye Turn/Weak Eye | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Retinal Detachment | ☐ | ☐ |

| Wome: | Yes | No |
|---|---|---|
| Are you pregnant? | ☐ | ☐ |
| Are you breast feeding? | ☐ | ☐ |

| | **Family Member** Yes | No | **Relationship (Blood Relatives Only)** |
|---|---|---|---|
| Blindness | ☐ | ☐ | _____ |
| Eye Turn | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ |
| Macular Degeneration | ☐ | ☐ | _____ |
| Retinal Detachment | ☐ | ☐ | _____ |

Other: _____

**Review of Systems: Please indicate below if you have or ever had problems with the following conditions:**

**Allergic/Immunologic**
- ☐ None
- ☐ Lupus (SLE)
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Other (i.e., Latex)

**Ear, Nose and Throat**
- ☐ None
- ☐ Sinusitis
- ☐ Upper Respiratory Tract Infection
- ☐ Other

**Gastrointestinal**
- ☐ None
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Acid Reflux/Ulcer
- ☐ Other

**Skin/Integumentary**
- ☐ None
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other

**Psychiatric**
- ☐ None
- ☐ Depression
- ☐ Bi-Polar
- ☐ Schizophrenia
- ☐ Other

**Cardiovascular**
- ☐ None
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Vascular Disease
- ☐ High Blood Cholesterol

**Endocrine/Glands**
- ☐ None
- ☐ Diabetes
- ☐ Hormone Dysfunction
- ☐ Thyroid Dysfunction
- ☐ Other

**Respiratory**
- ☐ None
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

**Muscle/Skeletal**
- ☐ None
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Other

**Genital/Urinary**
- ☐ None
- ☐ Urinary Tract Infection
- ☐ HIV Positive
- ☐ Herpes/Chlamydia
- ☐ Other

**Hematologic/Lymphatic**
- ☐ None
- ☐ Anemia
- ☐ Leukemia
- ☐ Bleeding Disorder
- ☐ Other

**Neurological**
- ☐ None
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tremors
- ☐ Other

**General Health**
- ☐ None
- ☐ Weight loss/gain
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma

**Social**
- ☐ Tobacco Use: Current Smoker Former Smoker
- ☐ Non-Prescription Drugs_____
- ☐ Alcohol Consumption_____drinks/week_____
- ☐ Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

**Acknowledgement of Receipt of Notice of Privacy Practices**

Name of Patient (Print): _____ Date:_____

Signature of Patient/ Pt Representative (if patient is a minor or an adult unable to sign this form):_____

Relationship of Patient Representative to Patient: _____