Burbank Optometric Center, Inc.

Adult Medical History - New and Established Patients

New patients: Please fill out form completely.

Established patients: Please provide any changes to your information and any new symptoms/problems/concerns.

Patient Information

Salutation: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Name:____

Address:____

City:________________________________ State: ______________ Zip Code:_____________

Home Phone: (____)__________ Cell Phone: (____)__________

Email:____

Date of Birth: ____ / ____ / ________ Social Security #: ____ - ____ - _____

Emergency Contact: Name: ____

Relationship: ___________________________________

Phone number: (____)__________

☐ I give permission for my personal health information to be released to the person named above.

Signature:____

How were you referred to our office? ☐ Google ☐ FB ☐ Yelp ☐ Internet ☐ Insurance ☐ Patient, First and last name:___________________________________

INSURANCE: Please bring all insurance cards with you.

Primary Vision Insurance Company Name:

Identification Number:

Group Number:

Insured's Name:

Insured's Date of Birth:

Patient's Relation to Insured:

Secondary Vision Insurance Company Name:

Identification Number:

Group Number:
Insured's Name:
Insured's Date of Birth:
Patient's Relation to Insured:

Primary Medical Insurance Company Name:
Identification Number:
Group Number:
Insured's Name:
Insured's Date of Birth:
Patient's Relation to Insured:

Secondary Medical Insurance Company Name:
Identification Number:
Group Number:
Insured's Name:
Insured's Date of Birth:
Patient's Relation to Insured:

SYMPTOMS: Check all that apply.

EYEGLASSES (Skip if you do not wear glasses)

☐ **I currently wear:**

☐ Non-prescription sun ☐ Non-prescription blue light/UV

☐ Single vision distance ☐ Single vision reading ☐ Single vision computer

☐ Single vision sunglasses ☐ Single vision safety ☐ Single vision sports

☐ Bifocal (lined) for distance/reading ☐ Bifocal for computer/reading

☐ Trifocal (lined)

☐ Progressive (no line) for everything ☐ Progressive for computer/reading

☐ Progressive sunglass ☐ Progressive safety ☐ Progressive sports

☐ **I am having problems with my current glasses:**

☐ Distance blur ☐ Computer blur ☐ Near blur

☐ Frame broke ☐ Frame loose ☐ Frame is uncomfortable

☐ Lost ☐ I want a new style

☐ **I need new glasses:** ☐ Everyday use ☐ Spare ☐ Sun ☐ Safety

☐ Sports ☐ Blue light/UV

CONTACT LENSES (Skip if you don't wear contacts)

What brand/name of contacts do you wear?

How old are your current pair of contacts?

How often do you dispose of your lenses?

What brand of solution do you soak your lenses in?

How many days per week do you wear your contacts? How many hours per day?

How many hours do you experience clear vision and good comfort?

Do you use eye drops? ☐ Yes, name and frequency of use: ☐ No

☐ **I am interested in changing/enhancing my eye color.**

☐ **I am interested in Transitions contact lenses.**

☐ **I am having problems with my current contacts:**

☐ Distance blur ☐ Computer blur ☐ Near blur

☐ Discomfort ☐ Dryness ☐ Old

☐ **I am interested in contact lenses but do not currently wear them.**

ELECTRONIC USE

Average # of hrs/day of electronics, including phone, tablet, computer, TV, gaming: ___________

# of monitors used:________ Working distance from monitor (measure from your eyes to the center of monitor):________

☐ **I am having symptoms of electronic overload:**

☐ Eyestrain ☐ Tired eyes ☐ Headaches ☐ Blurred vision

☐ Double vision ☐ Fluctuating vision ☐ Eye pain ☐ Light sensitivity

☐ **I am having symptoms of dry eye/allergy eyes:**

☐ Sandy/gritty feel ☐ Burning ☐ Tearing ☐ Redness

☐ Itching ☐ Dryness ☐ Blurred vision ☐ Mucous

☐Crusting around eyelashes

☐ **I am having trouble seeing at night:**

☐ Glare ☐ Can’t see ☐ Halos around lights

☐ **I am experiencing:** ☐ Floaters ☐ Flashes of lightc ☐ Shadows ☐ Loss of vision

☐ **I am interested in LASIK**

Please list any eye injuries, surgeries or infections you have ever had and when:

MEDICAL HISTORY:

Who is your primary care physician? ____

When was your last physical?__________ Results:__________________________________

Plan:____

List all prescription medications that you take: ___________________________________

List all over the counter supplements that you take: ________________________________

List all drug allergies:____

List any hospitalizations or surgeries you have had:__________________________________

List any specialists you see and for what conditions: ______________________________

Please check all medical diagnosis that apply to you:

☐ Chronic fever, unexpected weight loss/gain, fatigue

☐ Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)

☐ Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands or feet)

☐ Respiratory problems (eg. Shortness of breath, wheezing, coughing)

☐ Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)

☐ Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)

☐ Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)

☐ Skin problems (eg. Rashes, excessive dryness, growths or lumps)

☐ Neurological problems (eg. Numbness, weakness, headaches, "blackouts")

☐ Psychiatric problems (eg. Depression, anxiety)

☐ Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)

☐ Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)

☐ Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)

Social History:

Occupation: **Employer:**

Do you drink alcohol? ☐ Frequently ☐ Socially ☐ Infrequently ☐ Never

Do you smoke? ☐ Current daily ☐ Current not daily ☐ Former ☐ Heavy >10/day

☐ Light <10/day ☐ Never

Do you vape? ☐ Frequently ☐ Socially ☐ Infrequently ☐ Never

Do you take illegal drugs? ☐ Yes ☐ No

Family Eye History: Please check any eye conditions that run in your family (blood relatives), relation and age diagnosed:

☐ Glaucoma, who and age diagnosed ___________________________

☐ Macular degeneration, who and age diagnosed _________________

☐ wet (bleeding) ☐ dry (no bleeding)

☐ Retinal hole/tear/detachment, who and age diagnosed?________________________

☐ Cataracts, who and age diagnosed_____________________________

☐ Amblyopia (lazy eye), who? ___________________

☐ Strabismus (eye turn), who? ________________________

☐ Other (please explain) ______________

Family Medical History: Please check any health conditions that run in your family (blood relatives), relation and age diagnosed:

☐ High blood pressure, who? _____________________

☐ Diabetes, who? _____________________

☐ High cholesterol, who? _____________________

☐ Cancer, type? _____________________ who? ___________________

☐ Auto-immune disorders, type? _____________________ who?___________________

☐ Neurological (Alzheimer's, dementia, Parkinson's, etc.), type? _____________ who? ___________

Please return the completed questionnaire to us via your online portal at least one day before your appointment. Your login will be emailed to you. If you need assistance with your online portal, please call our office, 818-845-3549.

THANK YOU!

We look forward to seeing you soon!