

CAMARILLO VISION CENTER

Dr. Marty Schneider and Dr. Vicky Chow

Our Mission

It is our goal to provide our patients with the highest quality eye care and service. We are devoted to our community in and out of the office. Our knowledgeable staff and doctors are committed to excellence in meeting each patient's unique visual and eye health needs with the highest ethics and integrity.

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Name _____

Today's Date _____

Mailing Address _____

City, State, Zip _____

Date of Birth _____ Age _____ Sex: M F

Home Phone _____

Work Phone _____

Cell Phone _____

Social Security _____

Employer (or School) _____

Occupation (or Grade) _____

Are you: Minor Married Divorced Single Widowed

Guardian(if applicable) _____

E-Mail _____

How did you first hear about our office? _____

MEDICAL HISTORY

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Nerves | <input type="checkbox"/> Kidney Problems | |
| <input type="checkbox"/> Other _____ | | |

CURRENT MEDICATIONS (Rx or over the counter)

Medication Name

- | | |
|---|-------|
| <input type="checkbox"/> Antihistamines | _____ |
| <input type="checkbox"/> Blood Pressure Pills | _____ |
| <input type="checkbox"/> Diuretic (water pill) | _____ |
| <input type="checkbox"/> Oral Contraceptives | _____ |
| <input type="checkbox"/> Eye Drops | _____ |
| <input type="checkbox"/> Others | _____ |
| <input type="checkbox"/> Allergies to Medicines | _____ |

Date of Last Eye Exam _____

Name of Last Eye Doctor _____

Date of Last Physical Exam _____

Name of Physician _____

FAMILY MEDICAL HISTORY

Relationship to you

- | | |
|---|-------|
| <input type="checkbox"/> Blindness | _____ |
| <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Other | _____ |

Do you experience..... (check those that apply)

- | | |
|--|---|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Sudden loss of vision |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Fainting or dizziness |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Blurry distance vision |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Blurry near vision |
| <input type="checkbox"/> Glare or Reflection | <input type="checkbox"/> Gritty feeling in eyes |
| <input type="checkbox"/> Soreness | <input type="checkbox"/> Objects floating in vision |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Other |

VISUAL NEEDS

Do You..... (check the box if your answer is yes)

- | |
|---|
| <input type="checkbox"/> Work at a computer for long periods of time? |
| <input type="checkbox"/> Have only one pair of glasses? |
| <input type="checkbox"/> Want information on thinner, lighter lenses? |
| <input type="checkbox"/> Wear bifocals? |
| <input type="checkbox"/> Want information on lineless bifocals? |
| <input type="checkbox"/> Prefer not to wear your glasses at times? |
| <input type="checkbox"/> Spend a lot of time outdoors? |
| <input type="checkbox"/> Ever find a need for prescription sunglasses? |
| <input type="checkbox"/> Have problems with glare or reflections (ex: night driving)? |
| <input type="checkbox"/> Do work requiring safety glasses? |
| <input type="checkbox"/> Participate in sport activities? What? _____ |
| <input type="checkbox"/> Want more information about corrective vision surgery? |
| <input type="checkbox"/> Wear or ever tried wearing contacts? What kind? _____ |

Social History

- | |
|--|
| <input type="checkbox"/> Yes, I would prefer to discuss my Social History information directly with my doctor. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you use tobacco products? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Do you drink alcohol? |

The responsible party is required to pay for all deductibles, co-payments and/or co-insurance, and to pay any balance not covered by insurance.

Signature _____

Date _____