TOTAL VISION CAMARILLO

Dr. Marty Schneider, Dr. Vicky Chow & Dr. Jonathan Mak

Our Mission

It is our goal to provide our patients with the highest quality eye care and service. We are devoted to our community both 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

☐Allergies	☐Arthritis	☐Heart Disease
☐Asthma	☐Cancer	☐Skin Disorder
☐Diabetes	☐Cataracts	☐High Blood Pressure
☐Eye Injury	☐Eye Surgery	☐Glaucoma
☐Nerves	☐Kidney Problems	

☐Other _____

CURRENT MEDICATIONS (Rx or over the counter)

Medication Name

☐Antihistamines _____
☐Blood Pressure Pills _____
☐Diuretic (water pill) _____
☐Oral Contraceptives _____
☐Eye Drops _____
☐Others _____
☐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

☐Blindness _____
☐Glaucoma _____
☐Diabetes _____
☐High Cholesterol _____
☐Other _____

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

☐Burning	☐Uncomfortable glasses
☐Itchiness	☐Sudden loss of vision
☐Nausea	☐Sensitivity to light
☐Watery Eyes	☐Fainting or dizziness
☐Double Vision	☐Blurry distance vision
☐Flashes of Light	☐Blurry near vision
☐Glare or Reflection	☐Gritty feeling in eyes
☐Soreness	☐Objects floating in vision
☐Eye Strain	☐Trouble seeing at night
☐Headaches	☐Dryness
☐Redness	☐Other

VISUAL NEEDS

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

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

Social History

☐Yes, I would prefer to discuss my Social History information directly with my doctor.
☐ YES ☐ NO Do you use tobacco products?
☐ YES ☐ 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**