**San Pablo Optometric Center**

**14240 San Pablo Ave.**

**San Pablo, CA 94806**

**(510) 232- 3060**

Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Cell Phone#: (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insured Information**

Member’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Record**

**Do you have any problems with the following conditions? Check all that apply.**

\_\_ Gastrointestinal \_\_Nervous System \_\_Mental

\_\_ Ear/Nose/Throat \_\_Genitourinary \_\_Endocrine(Glands)

\_\_Cardiovascular \_\_Musculoskeletal \_\_Blood/Lymph

\_\_Respiratory \_\_Skin \_\_Allergic/Immunologic

\_\_ Headaches \_\_Surgeries (what type & when) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergic reactions to medications or other substances? \_\_Yes \_\_No

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of general physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check Yes or No**

Do you smoke? \_\_Yes \_\_No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcohol? \_\_Yes \_\_No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take medications? \_\_Yes \_\_No

Do you use other substances? \_\_Yes \_\_No If so, please list names & how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any family history on any of the following? Check all that apply**

\_\_Diabetes \_\_Glaucoma \_\_High blood Pressure

\_\_ Macular Degen. \_\_Cataracts \_\_ Retinal Detachment

**Please explain boxes you’ve checked**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following? Check all that apply**

\_\_Dry Eye \_\_Eye Surgeries \_\_Wear Glasses

\_\_ Blurred Vision \_\_Eye Injuries \_\_ Wear Contacts

Do you have any eye problem at this time? Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in wearing contacts? \_\_Yes \_\_No

**WOMEN ONLY:** Are you pregnant? \_\_Yes \_\_No Are you nursing? \_\_Yes \_\_No