WELCOME TO FAMILY VISION CARE OPTOMETRICS !

Gary M. Louie, O.D. & Associates

Mr./Mrs./Miss
Last _____ First _____MI ___
Street _____
City _____ State _____ Zip _____
Home ( )_____ Date of Birth: _____
Work ( ) _____ Age: _____ Sex: M F
Cell ( ) _____ E-mail: _____
Occupation _____ (if child,
Employer _____ parent's employer)
Spouse's Name _____
Spouse's Occupation _____ Work Phone: ( )_____
How did you hear about our office? Yellow Pages Sign/Building
Friend or Relative _____ Insurance Plan
Internet
Do you currently wear glasses? Y N Contact Lenses? Y N
Were they prescribed for: Distance Only Near Only Both
Do you wear prescription sunglasses? Y N
How many pairs of prescription glasses do you use?_____

Vision Plan (circle) VSP Davis MESC Other _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birthdate _____

Medical Plan(circle) Kaiser Blue Cross MediCare
Other _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birthdate _____
Payment Type (circle) Cash Check Credit Card
Do you participate in a Flex Spending Account? Y N

Do you have children? Y N If yes, names and ages: _____
_____

OCULAR AND MEDICAL HISTORY

When was your last complete eye examination? _____ Who was your last eye doctor? _____
What is your primary complaint or problem? _____
Have you recently experienced any of the following: (**CIRCLE** "**Y**" for Yes or "**N**" for No for each item)

Y N Blur at distance	Y N Difficulty changing focus	Y N Flashes of light
Y N Blur at near	Y N Itching	Y N Floating spots
Y N Pain	Y N Burning	Y N Cloudiness or curtain in your vision
Y N Redness	Y N Dryness	Y N Poor night vision
Y N Frequent headaches (see back of form)	Y N Sandy or gritty sensation	Y N Halos around lights
Y N Double vision	Y N Excessive tearing/watering	Y N Glare at night
Y N Eye infection	Y N Light Sensitivity	Y N Momentary loss of vision

HPI: Location Quality Severity Duration Timing Context Moderating factors Associated S/S_____
_____
_____
_____

Do you have a current or past history of:

Y N Eye injury	Y N Eye surgery	Y N Eye muscle imbalance
Y N Lazy eye	Y N Eye turn	Y N Eye Disease - Name:

When was your last complete **PHYSICAL** examination? _____ What is your doctor's name? _____
Do you or any of your blood relatives have a history of: (**CIRCLE** "**Y**" for Yes or "**N**" for NO in "SELF" column. If a blood relative has had that condition, indicate which relatives by: F=father, M=mother, GF=grandfather, GM=grandmother, U=uncle, A=aunt in "Relatives" column.

CONDITION	SELF	RELATIVES
	(circle)	
High Blood Pressure	Y N	Y N
Diabetes	Y N	Y N
Hardening of arteries	Y N	Y N
Heart attack	Y N	Y N
Stroke	Y N	Y N
Kidney or liver disease	Y N	Y N
High Cholesterol	Y N	Y N
Cancer (type:)	Y N	Y N

CONDITION	SELF	RELATIVES
	(circle)	
Heart disease	Y N	Y N
Thyroid disease	Y N	Y N
Joint disease	Y N	Y N
Glaucoma	Y N	Y N
Blindness	Y N	Y N
Retinal detachment	Y N	Y N
Macular Degeneration	Y N	Y N
Other:		

_____
_____
Please list any medications you are currently taking: _____ ❑ None
Do you have any allergies? ❑ hayfever/seasonal ❑ asthma ❑ to medications (please list: _____) ❑ None
Do you currently use: (**CIRCLE** Yes or No) a) alcohol Y N b) tobacco products Y N c) controlled substances Y N

LIFESTYLE HISTORY: (circle all choices that apply to you) Do you regularly participate in any of the following:

❑ Baseball , Basketball	❑ Golf	❑ Needlework/coin collecting	❑ Home workshop/auto repair
❑ Football	❑ Snow skiing	❑ Musical instrument	❑ Computer use
❑ Bicycle/Motorcycle riding	❑ Fishing/Boating	❑ Welding/grinding	❑ Other:
❑ Diving/swimming	❑ Shooting/hunting	❑ Playing cards	

Are you interested in any of the following:
❑ Thinner, lighter lenses ❑ Reducing glare/reflections ❑ "Test Driving" latest contact lenses ❑ Lasik surgery

CURRENT EMERGENCY CONTACT INFORMATION: **Name** _____ **Phone Home** ( )_____
Relationship _____ **Cell** ( ) _____

P L E A S E T U R N O V E R !

DIGITAL RETINAL PHOTOGRAPHY

To Our Patients:

Our office continues to offer the latest in technology in order to provide the best service to our patients! Recently, we have introduced two additional technological advances to our office to benefit our patients!

Optomap Scanning Laser Retinal Imaging System. This allows us to see a broad, detailed view of the retinal similar to that seen with a dilated examination. We can document and record many retinal problems such as optic nerve disease, macular degeneration, diabetic eye disease, glaucoma, and so on. The scan becomes a permanent part of your medical file, enabling us to make important comparisons should potential vision or life-threatening conditions show themselves at a future examination. Although it is similar to the digital retinal photography system we have had, it offers a much wider field of view that can, in qualified patients, be an alternative to a dilated examination for that year. Our doctors recommend this for all of our patients on an annual basis. We offer our basic Wellness scan for $39 for adults & $24 for ages 21 yrs and under.

Please indicate below if whether or not you would like to have this procedure provided for you.

YES I do want to have the Optomap Scanning performed.
NO I do NOT want to have this procedure performed at this time.

Signed: _____ Date: _____

Optovue SD-OCT (Spectral Domain Optical Coherence Tomographer). This has been the most significant advance in ocular disease detection in many years! Similar to a CT or MRI scan but using visible light, this amazing technology allows us to see beneath the surface of the retina and detect changes invisible to standard examination. We have been able to not only diagnose suspected eye conditions; it has uncovered conditions that we did not even suspect were present! Very few optometric offices have this technology in their offices at this time. We offer an advanced medical scan for $90 and a basic Wellness scan for $39.

Many medical insurance plans will cover the advanced Optomap or OCT scans if there is a qualifying medical condition present.
Please indicate below if whether or not you would like to have this procedure provided for you.

YES I do want to have the OCT Scanning performed.
NO I do NOT want to have this procedure performed at this time.

Signed: _____ Date: _____

CONTACT LENS HISTORY:

If you are wearing contact lenses, how many hours have you had them on today? _____ Are the lenses: hard soft
How many hours do you usually wear them each day? _____
Number of days per week? _____
If using soft lenses, how frequently do you replace them:(fill in number)
____yr. ____ mos. ____ weeks ____day
How old are the lenses you have on today? _____
What brand of contact lenses are you using? _____
What brand of CL solutions are you currently using? _____
Have you recently experienced any of the following with your lenses? (**CIRCLE** "Y" for Yes or "N" for No for each item)

Y	N	Irritation	Y	N	Reduced wearing time
Y	N	Edge reflections	Y	N	Itchiness
Y	N	Flare around lights	Y	N	Discharge/watering
Y	N	Cloudy vision	Y	N	Discomfort or dryness
Y	N	Fluctuating vision			at the end of the day

FREQUENT HEADACHE HISTORY:

When did the headaches first start occurring? _____
How long do they last? _____
How frequently do you have headaches? _____
When does the pain occur? on awaking mornings after lunch after work bedtime
Where on your head is the pain located?
back forehead top temples brows
side(s) (left right both)
Is the pain: (sharp dull pressure-like)
(steady throbbing (as with heartbeat))
(mild moderate severe)
What relieves the pain? _____
Is the severity of the pain (more less same) than when they first started?
Do the headaches affect your vision? yes no Describe:
_____
Do you also experience any of the following around the time you headaches occur? Nausea Flashing lights Partial loss of vision

I testify that the above information is accurate and true.
Signed: _____ Date: _____
Print Name: _____

Would you like to receive a copy of your glasses and/or contact lens prescription for your records at the end of the examination or would you prefer to keep them in your file? (Please circle)
Glasses: Copy Keep in file
Contact lenses: Copy Keep in file