Fairway Park Optometry Center

Dr. Ximena Daza *Dr. Donna Madlangbayan*

PATIENT INFORMATION

Check One: □ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Minor Today's Date: _____
Name: _____
Address: _____ Date of Birth: _____
_____ Social Security #: _____
Home Phone; _____ Is Responsible Party the patient? □ Yes □ No
Cell Phone #: _____ Last Eye Exam: _____
email: _____ Last Prescription: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Work Address: _____ Work Phone: _____
_____

REFERRAL INFORMATION

How did you find out about us? □Insurance list □Walked by □Internet
□Doctor _____ □Existing patient _____

Name of Vision Insurance: □ VSP □ MES □ Eye-Med □ Medi-care □ Medi-Cal □ None
Name of Primary Medical Insurance: _____ Group No. _____

MEDICAL HISTORY

1. Do you have any allergies to medications? □ No □Yes If yes,
explain: _____
2. List any medication you take(include oral contraceptives, aspirin, over the counter and home remedies):

_____
_____
_____

3. List all major injuries, surgeries and/or hospitalizations you have had:

_____
_____

4. Have you ever been told you had any of the following?(mark where appropriate)

□crossed eyes	□eye infections	□dry eyes
□prominent eyes	□glaucoma	□diabetes
□lazy eye	□cataracts	□hypertension
□drooping eyelid	□macular degeneration	□stroke
□eye injuries	□retinal disease	

5. Are you pregnant or nursing? □No □Yes
6. Do you wear glasses? □No □Yes If yes how old is your present pair? _____
7. Do you wear contact lenses? □No □Yes If yes how old is your present pair? _____
8. What type of contact of lenses? □Rigid □Soft □Extended wear □Other
9. Are they comfortable? □No □Yes

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SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

☐ YES, I would prefer to discuss my Social History information directly with my doctor.

1. Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving?
   ☐ No ☐ Yes If yes, describe: _____
2. Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long: _____
3. Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: _____
4. Do you use illegal drug? ☐ No ☐ Yes If yes, type/amount/how long: _____
5. Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEMS	NO	YES	?
Constitutional			
Fever, weight loss/gain	☐	☐	☐
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision	☐	☐	☐
Loss of side vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign body sensation	☐	☐	☐
Excess tearing	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Eye pain/soreness	☐	☐	☐
Chronic infection	☐	☐	☐
Sty/chalazion	☐	☐	☐
Flashes/floaters in vision	☐	☐	☐
Tired eyes	☐	☐	☐
Endocrine	☐	☐	☐
Thyroid/other glad	☐	☐	☐

SYSTEM	NO	YES	?
Ears, Nose, Mouth, Throat			
Allergies/Hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/cardiovascular			
Diabetes	☐	☐	☐
Heart pain	☐	☐	☐
High blood pressure	☐	☐	☐
Vascular disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/kidney/bladder	☐	☐	☐
Bones/joints/muscles			
Rheumatoid arthritis	☐	☐	☐
Muscle pain	☐	☐	☐
Joint pain	☐	☐	☐
Lymphaatic/hematologic			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
Allergic/immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered YES to any of above or have a condition not listed, please explain and list medications:

_____

_____

_____

I understand that if my insurance cannot provide prior guarantee of payment, I will be responsible for all charges incurred at the time of service. I hereby authorize Fairway Park Optometry Center to release information applicable to benefits payable for services.

Signature: _____ Date: _____