Diablo Valley Optometric Group

Welcome to Our Office

Today's Date_____

Patient Information

Last Name_____

First Name_____Middle Initial_____

Date of Birth_____Age_____

Birth Sex: F M Patient's SSN_____

Address_____

City_____State____Zip Code_____

Cell/primary phone number_____

Secondary phone number_____

Employer (or School)_____

Occupation (or Grade)_____

Spouse (or Parent's Name)_____

Spouse (or Parent's Work)_____

Email Address_____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office?

- ☐ Internet Search - Google, Bing, etc.
- ☐ Another Doctor
- ☐ Insurance List
- ☐ Saw Sign/Building
- ☐ Social Media - Instagram or Facebook

To ensure timely access to care for all patients, Diablo Valley Optometric Group requires a 24-hour notice for appointment cancellations. A 'no-show' appointment, defined as missing a scheduled appointment without prior notification, may result in a $50 charge added to your account. This fee is not covered by insurance and must be paid before scheduling future appointments. In case of emergencies or extenuating circumstances, please contact our office to discuss the possibility of waiving the no-show fee. By scheduling an appointment, you agree to abide by this policy.

Insurance Information

Vision Insurance _____

Subscriber Name_____

Subscriber SSN _____

Subscriber Date of Birth_____

Primary Medical Insurance_____

Subscriber Name_____

Subscriber SSN _____

Subscriber Date of Birth_____

Do you participate in a flex spending account?
Yes No

Lifestyle Questions

Check the box if your answer is yes

Do you ...

- ☐ work at a computer?
- ☐ think you might benefit from thinner, lighter lenses?
- ☐ spend time outdoors? How much? ___hrs/ week
- ☐ have prescription sunwear?
- ☐ prefer not to wear your glasses at times?
- ☐ want information on Laser Correction surgery?
- ☐ have interest in a non-surgical approach to vision correction?
- ☐ have more than 1 pair of current Rx eyewear?
- ☐ have children?
- ☐ have family members in the need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Crossed Eye/Eye turn
- ☐ Eye Infections
- ☐ Flash of light
- ☐ Glaucoma
- ☐ Headaches
- ☐ Itchiness
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Tearing
- ☐ Uncomfortable glasses
- ☐ Other eye disorders
- ☐ Burning
- ☐ Corneal Abrasions
- ☐ Double Vision
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Iritis/Uveitis
- ☐ Lazy Eye
- ☐ Occasional dryness
- ☐ Sunlight Sensitivity
- ☐ Trouble seeing at night

The information in this confidential history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____

City/Town_____

Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)

List name of medications including eye drops, vitamins, supplements, etc.

_____

_____

_____

_____

Allergies to medications? Yes No

If so, what medications? _____

_____

_____

Have you had any surgeries? Yes No

If yes, What kind? _____

_____

Do you use cigarettes/tobacco, alcohol or other substances?

Yes No

Have you ever been diagnosed or treated for the following health problems?

Allergies	Yes	No
Arthritis	Yes	No
Blood/Lymph	Yes	No
Bronchitis	Yes	No
Cancer	Yes	No
Cholesterol	Yes	No
Diabetes	Yes	No
Digestive	Yes	No
Ears/Nose/Throat	Yes	No
Endocrine	Yes	No
Eczema/Rashes	Yes	No
Fatigue	Yes	No
Fevers	Yes	No
Genitourinary	Yes	No
High Blood Pressure	Yes	No
Integumentary (Skin)	Yes	No
Kidney	Yes	No
Muscle/Bone	Yes	No

Patient Eye History

Date of Last Eye Exam_____

By Whom?_____

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No

What kind?_____

Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses?

Yes No

If you wear bifocals, do the lines or head tilting bother you?

Yes No

Family Medical/Eye History

Is there any family history of any of the following:
Check box and indicate Mother's or Father's side

- ☐ Blindness_____
- ☐ Cataracts_____
- ☐ Corneal Problems_____
- ☐ Diabetes_____
- ☐ Glaucoma_____
- ☐ Heart Disease_____
- ☐ Lazy Eye_____
- ☐ Macular Degeneration_____
- ☐ Retinal Problems_____

Thank you for your trust in our office!

Michael Ottati, O.D.
Christabelle Trinh, O.D.
Celia Futch, O.D.