

# 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?

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

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.  
Celia Futch, O.D.