

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
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
Seizure/Epilepsy	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.
Emily Choh, O.D.