

# Morro Bay Optometry - Patient Information Form

Please fill out this form and bring it with you to your appointment

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS : RESIDENCE \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

MAILING \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S WORK PHONE \_\_\_\_\_

YOUR OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DATE OF LAST VISION EXAM \_\_\_\_\_ DOCTOR \_\_\_\_\_

1. LIST ANY **EYE** CONDITIONS, EYE INJURIES, INFECTIONS, OR EYE OPERATIONS YOU HAVE HAD IN THE PAST  
\_\_\_\_\_
2. CIRCLE ANY **EYE** CONDITIONS YOU NOW HAVE: blurred vision, double vision, dry eyes, mucous, redness, itching, burning, tearing, light sensitivity, eye pain, sties, flashing lights, spots of vision, tired eyes, glaucoma, cataract, headaches, other.
3. DO YOU HAVE PROBLEMS WITH ANY OF THESE **SYSTEMS**: (PLEASE CIRCLE) cardiovascular, gastrointestinal, respiratory, sinus/nose/throat, nervous, genitourinary, musculoskeletal, skin, eyes, mental, endocrine, blood, allergy. Explain \_\_\_\_\_
4. LIST ANY MEDICATIONS YOU CURRENTLY TAKE: \_\_\_\_\_
5. LIST ANY MEDICATIONS YOU ARE **ALLERGIC** TO: \_\_\_\_\_
6. CIRCLE ANY CONDITIONS A **FAMILY** MEMBER HAS BEEN DIAGNOSED WITH: high blood pressure, diabetes, glaucoma, macular degeneration, cataract, retinal detachment, crossed eyes.
7. CIRCLE CONDITIONS THAT YOU HAVE BEEN INFECTED WITH OR EXPOSED TO: gonorrhea, hepatitis, HIV, syphilis, TB.
8. CIRCLE ANY OF THE FOLLOWING THAT YOU REGULARLY USE: tobacco, alcohol, other substances.
9. FAMILY DOCTOR \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_
10. NAME OF PRESENT VISION INSURANCE \_\_\_\_\_ MEDICAL INSURANCE \_\_\_\_\_
11. I understand that I am responsible for all charges for services provided by Tiffany Smart, O.D. I authorize release of any medical information necessary to process my insurance claims and request payment of any benefits due to be paid directly to Tiffany Smart, O.D.  
  
Patient Signature \_\_\_\_\_ DATE \_\_\_\_\_
12. If under 18 years old, responsible party and phone #: \_\_\_\_\_