Customized Vision Care

428 S. Brea Blvd. Brea, CA 92821
(714) 529-2470

The information in this confidential personal history form is critical to the evaluation of your vision

Patient Name _____ Date _____

Address _____ City _____ Zip code _____

Home Phone (_____) _____ Email address _____

Date of Birth _____ Occupation _____

Employer _____ Work Phone (_____) _____ Ext _____

Emergency contact name _____ Phone Number (_____) _____

Social Security # _____/_____/_____ Person Responsible for account _____

Insurance that covers vision care? ☐Yes ☐ No ☐VSP ☐ MES ☐Medicare Other _____

Date of last eye exam _____ Have you ever had vision therapy? ☐Yes ☐No

Have you ever worn glasses? ☐Yes ☐ No Do you wear glasses now? ☐Yes ☐ No

If yes: ☐for distance only ☐for near only ☐wear them full time ☐for computer monitor ☐sports

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS-Why are you here today?

List all eye health problems/symptoms*: _____

*Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching, glaucoma, cataracts, floaters, dry eyes, etc.

Please answer the following by circling:

Location	**Which eye has the problem?**	Right eye – Left eye – Both eyes
Quality	**Does the problem cause vision loss or blur?**	Loss – Blur
Context	**Did the problem occur suddenly or gradual?**	Sudden – Gradual
Severity	**How severe is the problem?**	Mild – Moderate – Severe
Modifying Factors	**Is it worse at any specific distance?**	Distance – Near –Computer
Duration	**How long does the problem last?**	Intermittent – Constant
Timing	**How long has the problem been occurring?**	Short term – Long term
Associated Symptoms	**Are there associated symptoms?**	No – Headache – Pain - Light Sensitivity – Other_____
Previous Interventions	**Does anything help the problem?**	Nothing helps – Nothing has been tried-Other_____

REVIEW OF SYSTEMS – Check inside the boxes if you have a problem with any of the following: **(1, 2, 10)**

Eyes	Y	N
Loss of vision	[ ]	[ ]
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed eyes	[ ]	[ ]
Flashes	[ ]	[ ]
Floaters	[ ]	[ ]
Dry eyes	[ ]	[ ]
Watery eyes	[ ]	[ ]
Red eyes	[ ]	[ ]
Mucous discharge	[ ]	[ ]
Burning or itching	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Light sensitivity	[ ]	[ ]
Chronic eye infections	[ ]	[ ]
Tired eyes/Eyestrain	[ ]	[ ]
Halos/Glare	[ ]	[ ]
Previous Vision Therapy	[ ]	[ ]
Previous Eye surgery	[ ]	[ ]
Previous Eye injury	[ ]	[ ]
Retinal detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]

If you answered yes to eye injury or eye surgery, please explain :

_____

_____

Allergic/Immunologic	Y	N
Hay fever/Allergies	[ ]	[ ]
Medicine allergies	[ ]	[ ]
Lupus	[ ]	[ ]
Sjogrens	[ ]	[ ]
Constitutional symptoms		
Fever	[ ]	[ ]
Recent Weight loss	[ ]	[ ]
Cardiovascular		
Heart disorder	[ ]	[ ]
High blood pressure	[ ]	[ ]
Vascular disease	[ ]	[ ]
Ears, Nose, Mouth, Throat		
Sinus problems	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Chronic ear infections	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Other glands	[ ]	[ ]

If you answered YES to high blood pressure, what was your last blood pressure measurement? _____

If you answered YES to diabetes, when were you diagnosed? _____

List your last Blood Sugar: _____

List your last Hemoglobin A1C: _____

Genitourinary	Y	N
Genitals	[ ]	[ ]
Kidneys or Bladder	[ ]	[ ]
Hematologic/Lymphatic		
Anemia	[ ]	[ ]
High cholesterol	[ ]	[ ]
Integumentary		
Skin	[ ]	[ ]
Breast	[ ]	[ ]
Musculoskeletal		
Arthritis	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Muscle pain/Joint pain	[ ]	[ ]
Neurological		
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]
Psychiatric		
Nervous disorders	[ ]	[ ]
Depression	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Emphysema	[ ]	[ ]
Lung cancer	[ ]	[ ]

List any other medical conditions not listed above: _____

PAST, FAMILY AND/OR SOCIAL HISTORY- Please answer the following. Please write NA, if it does not apply (1, 3)

Personal Medical History:

Have you had any major illnesses, injuries, or operations? ☐Y ☐N Explain:_____

Are you taking any medications (prescription and over-the-counter)? ☐Y ☐N List:_____

Date of Last Medical Exam: _____ Doctor: _____ For women: Pregnant/nursing? ☐Y ☐N

Family Health History: Please circle any condition in your family history and indicate relative affected.

Glaucoma	_____	Corneal Problem	_____	Diabetes	_____
Macular Degen	_____	Crossed eyes	_____	Heart Disease	_____
Retinal Problem	_____	Lazy eye	_____	High Blood Pressure	_____

Social History: Your occupation/grade: _____ Place of employment/school: _____

List your sports, hobbies, or special visual needs: _____

How many hours do use a computer a day? _____ Have you been exposed to Herpes, HIV, TB, Hepatitis? ☐ Y ☐N _____

Do you use tobacco products? ☐Y ☐N Do you drink alcohol? ☐Y ☐N Do you use recreational drugs? ☐Y ☐N

Please list all family members in your household: _____ age: _____ _____ age:_____

_____ age:_____ _____ age: _____ _____ age:_____

CONTACT LENSES:

Do you wear contact lenses at this time?	☐Yes	☐No	What type? _____
Have you had problems wearing contacts?	☐Yes	☐No	Describe_____
Have you been told you cannot wear them?	☐Yes	☐No	Reason _____
Are you interested in trying contacts?	☐Yes	☐No	

OCCUPATION: What kind of work do you do? _____

What activities do you do at work? (Check all that apply) ☐driving ☐typing ☐data entry ☐computers ☐accounting ☐writing/editing ☐using spreadsheets ☐loading ☐deliveries ☐ sales ☐Inspecting

Other activities: _____

Do you use a computer on the job?	☐Yes	☐No	_____# hours daily		
Do you use a computer at home?	☐Yes	☐No	_____# hours daily		
What lenses do you wear?	☐None	☐glasses	☐bifocals	☐progressive	☐contacts
When on the computer, do your eyes get:	☐red	☐dry	☐ache	☐sore	
Do you feel pain or discomfort in your:	☐neck	☐back	☐shoulders		
Do letters ever seem to "swim"?	☐Yes	☐No			
Does office lighting ever bother you?	☐Yes	☐No			
Do reflections and glare bother you?	☐Yes	☐No			
Is it hard to proofread or find errors?	☐Yes	☐No			

Do you experience any of the following discomforts at work or a home? (Check all that apply)

☐Headaches ☐Letters blur as you read ☐Occasionally see double ☐Eyestrain ☐Eyes red or water

☐Pulling sensation near eyes ☐Get sleepy ☐Lose place often

Do you avoid certain tasks? ☐Yes ☐No What tasks? _____

Does it take more and more effort to see clearly as the day wears on? ☐Yes ☐No

Do you avoid reading after work, but read on weekends? ☐Yes ☐No How long can you read? _____

Do you "hunch" closer to your work as the day wears on? ☐Yes ☐No

Do street signs ever seem blurred as you drive home from work? ☐Yes ☐No

Is it ever difficult to bring print or objects to clear focus? ☐Yes ☐No When? _____

Reviewed by: _____

Payment terms: We are happy to assist you in filing your insurance claim. If your insurance does not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. We accept cash, personal checks, Visa, and MasterCard. I have read and agree to all the provisions of the payment terms.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Drs. David Kirschen and Isabell Choi's Notice of Privacy Practices

Patient Name_____ Legal Guardian _____

Signature _____ Date_____