VAN PHAN, O.D. PLACENTIA FAMILY OPTOMETRY

Patient Registration and Health History **Date:_____**

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Child

Name:_____Gender: M / F Age:_____Birthdate: _____
Parent's Name (if patient is a minor)_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: Home (_____)_____ Cell (_____)_____ Work (_____)_____
Email:_____ Occupation: _____ Employer:_____
How did you hear about us? ☐ Friends/ Family ☐ Insurance ☐ Website ☐ Walk-In ☐ Other:_____
Emergency Contact: Name:_____ Relationship:_____ Phone: (____) _____

Insurance Information (if applicable):

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent Insured's date of birth: _____

Insured's Name: _____ Insured's Employer: _____

Insured's ID#: _____ Insurance Plan Name: _____ Auth. No.:_____

Please check this box if there have been no changes to your medical and ocular history since your last visit.

Personal Eye/ Medical History

What is the reason for seeking vision care? _____
_____

Visual symptoms (check each you have): ☐ None, routine eye examination

☐ Blurred distance vision	☐ Eye strain	☐ Seeing flashing lights/floaters
☐ Blurred near vision	☐ Headaches related to eyes	☐ Temporary loss of vision
☐ Burning eyes	☐ Itching eyes	☐ Twitching eyelids
☐ Double vision	☐ Light sensitivity	☐ Variable vision
☐ Dry eyes	☐ Red eyes	☐ Watery eyes

Do you or your immediate family have any of the following medical or eye conditions?: ☐ None

Self	Family	Whom?		Self	Family	Whom?		Self	Family	Whom?	
☐	☐	_____	Arthritis	☐	☐	_____	Gastrointestinal	☐	☐	_____	Migraines/Headaches
☐	☐	_____	Asthma	☐	☐	_____	Glaucoma	☐	☐	_____	Macular Degeneration
☐	☐	_____	Blindness	☐	☐	_____	Heart Condition	☐	☐	_____	Poor Color Vision
☐	☐	_____	Cancer	☐	☐	_____	High Blood Pressure	☐	☐	_____	Skin Conditions
☐	☐	_____	Cataracts	☐	☐	_____	Kidney Problems	☐	☐	_____	Thyroid Condition
☐	☐	_____	Diabetes	☐	☐	_____	Lazy Eye (amblyopia)	☐	☐	_____	Tuberculosis

When was your last eye exam? _____ Last Physical? _____ Name of Physician:_____

Are you pregnant? ☐ Y ☐ N Are you currently nursing? ☐ Y ☐ N

Are you presently taking any medication or drugs? ☐ Y ☐ N. If yes, which drugs are you taking? _____
_____

Are you allergic to any medications? ☐ Y ☐ N If yes, which? _____

Have you had any serious eye injuries, eye disease or eye surgery? ☐ Y ☐ N

If yes, please explain: _____

Do you smoke, consume alcohol, or use recreational drugs? ☐ Y ☐ N If yes, please explain: _____

SIGNATURE _____ **Dr. Initials _____**

Name: _____ DOB: _____ Age: _____ M F Date _____

CC: Blur Dist Near _____

Degree of problem (1-10) ____ Onset: _____ Frequency: _____ Duration: _____ Relief: _____

PEH: LEE: _____ ( ) Inj _____ ( ) Surg _____ ( ) Glc _____ ( ) F / F _____ Other: _____

PMH: LPE: _____ ( ) HTN ___ ( ) DM ___ ( ) HA ___ ( ) Hrt Dz ___ ( ) Lung ___ Other: _____

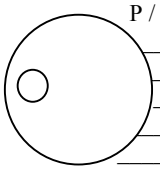
FEH: ( ) Blindness _____ ( ) Glc _____ ( ) Eye Dz _____ Other: _____

FMH: ( ) HTN _____ ( ) DM _____ Other: _____

Current Meds: _____ **Allergies:** _____

Dist VA OD 20 / Sc / Cc OS 20 / OU/	Near VA OD 20/ Sc / Cc OS 20/ OU	CURRENT Rx years: OD _____ (20 /) ADD (RS /) OS _____ (20 /) ADD (RS /)
PERRLA ( ) APD HB OD OS 0 .5 1 0 .5 1	EOM: ( ) RESTRICTION ( ) FULL ( ) SMOOTH NPC _____ cm__	CONFRONTATION FTFC AMSLER GRID PERIMETRY ATTACHED
STEREO / FUSION RL W4D	BP TIME:	
TIME: _____ AM / PM NCT OD _____ GAT OS _____	TIME: _____ AM / PM NCT OD _____ ( ) DILATED GAT OS _____ ☐ ALL NORMAL	COVER TEST CC / SC 6M / 40 CM
COLOR VISION OD ---------- OS ----------		
RET OD 20 / OR ---------- AUTOREFR OS 20 /	KER Y OD: X OS: X	DIST: PHORIA NEAR:
OD 20 / DIST ---------- SUBJ OS 20 /	BI / / DIST BO / / BU / BD /	BI / / NEAR BO / / BU / BD /
OD 20 / Add ---------- OS 20 /	NRA PRA Xcyl RANGE: cm	AMP / / FAC / /
ANGLE EST. OD 1 2 3 4 OS 1 2 3 4	( ) TROPICAMIDE 1% ___gtt_____am/pm ( ) PAREMYD ___gtt_____am/pm ( ) PHENYLEPHRINE 2.5% ____gtt_____am/pm ( ) CYCLO 1%___gtt_____am/pm OTHER:	DILATION: Y N DIRECT BIO 78D / 90D

	OD	OS
LIDS/LASHES	CL	CL_____
CONJ	CL	CL _____
CORNEA	CL	CL_____
AC	CL	CL_____
IRIS	FLT	FLT_____
LENS	CL	CL_____
ANT VIT	CL	CL_____



OD	OS	
DIST P / H	DIST P / H	**ONH MARGIN**
___x_____	_____x_____	**RIM TISSUE**
		C / D
		RNFL
_____	_____	**A / V**
		MACULA
		BCKGRD
		PERIPHERY

ASSESSMENT

[ ] **H52.1_(1, 2, 3)** MYOPIA [ ] **H52.22_ (1, 2, 3)** ASTIGMATISM [ ] **H52.0_(1, 2, 3)** HYPEROPIA [ ] **H52.4_ (1, 2, 3)** PRESBYOPIA

PLAN: **[ ]** DIST Rx [ ] NEAR Rx [ ] BF [ ] PROG DFE Pt.Ed [ ]Final rx same as Subject Refraction

s c a bc dia or va ASSESSMENT

L FITTING									
	OD								
	OS								

☐ good fit, comfort, va ou ☐ clrx released

☐ no contraindictions to CL wear ☐ rt if pain/discharge, d/c

☐ patient proficient w/ IR cl asap

_____

_____

SIGNED: _____ **O.D** **Return Visit: 1 2 year(s)**