San Luis Obispo Eye Associates

689 Tank Farm Road, San Luis Obispo, CA 93401
Phone (805) 781-3937 Fax (805) 781-9013

234 Heather Court, Templeton, CA 93465
Phone (805) 434-5970 Fax (805) 434-597

NEW PATIENT MEDICAL HISTORY

Patient name: _____ **DOB:** _____ **Age:** _____

Preferred name or nickname _____ **(circle one below) Male / Female / Non-Binary / Do not wish to state**

Primary Care Physician: _____ **Who referred you to this office?** _____

PREVIOUS EYE EXAMS AND GLASSES

- **What do you wear for vision correction?** (circle all that apply) **Glasses Reading glasses Contacts Nothing**
- **Who performed your last eye exam?** _____ **When?** _____
- **When was your glasses or contact prescription *last changed*?** _____

MEDICAL EYE HISTORY

Please place an "X" next to any of the following eye problems you are *currently* having.

_____ Blurred vision	____ Headaches	_____ Excessive tearing	_____ Crossed eyes
_____ Distorted vision	____ Itching	_____ Flashing lights	_____ Wandering eyes
_____ Difficulty reading	____ Redness	_____ Floaters	_____ Squinting
_____ Hold things too close	____ Pain	_____ Extreme light sensitivity	_____ Double vision
_____ Hold things too far	____ Discharge	_____ Eye discomfort	_____ Head tilt
_____ Scratchy	____ Other (please list)	_____	

Have you ever had any of the following eye conditions?

Cataract	**Yes / No**	**Retinal detachment**	**Yes / No**	**Lazy eye (amblyopia)**	**Yes / No**
Glaucoma	**Yes / No**	**Macular degeneration**	**Yes / No**	**Crossed eyes (strabismus)**	**Yes / No**
Corneal disease	**Yes / No**	**Other: (please list)**	_____		

GENERAL MEDICAL HISTORY

Please place an "X" next to any of the following problems you are *currently* having.

_____ Diabetes	_____ Stroke	_____ Cancer	____ AIDS or HIV
_____ High blood pressure	_____ Kidney disease	_____ Hepatitis	____ Extreme weight gain or loss
_____ Heart disease	_____ Liver disease	_____ Arthritis	____ Headaches
_____ Asthma or emphysema	_____ Thyroid disease	_____ Tuberculosis	____ Poor hearing

Do you have a family history of any of the following? Yes / No If yes, indicate which relative(s)

Cataract	_____	**Cancer**	_____	**Retinal detachment**	_____
Glaucoma	_____	**High blood pressure**	_____	**Amblyopia (lazy eye)**	_____
Diabetes	_____	**Macular degeneration**	_____	**Strabismus (crossed eyes)**	_____

Do you smoke? Yes / No If yes, how many per day? _____

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SURGICAL HISTORY

Please list all previous eye surgeries, if any:

Type of surgery: _____ **Right eye / Left eye** **Date:** _____

Type of surgery: _____ **Right eye / Left eye** **Date:** _____

Type of surgery: _____ **Right eye / Left eye** **Date:** _____

Please list all other surgeries, if any, and the approximate year they were done:

Type of surgery: _____ **Date:** _____

Type of surgery: _____ **Date:** _____

Type of surgery: _____ **Date:** _____

Have you ever had a bleeding problem? Yes / No **If yes, please describe:** _____

Have you or a blood relative ever had a problem with anesthesia? Yes / No **If yes, please describe:** _____

MEDICATIONS

Please list all prescription and non-prescription eye medications you are currently using, which eye, and how often.

Name **Eye** **How often**

Name **Eye** **How often**

Name **Eye** **How often**

Please list all other prescription and non-prescription medications you are taking, dosage and how often.

Name **How often**

Name **How often**

Name **How often**

ALLERGIES

Please list medication allergies and reaction

Name **Reaction**

Name **Reaction**

FOR CHILDREN ONLY

Birth Weight: _____ **Length of pregnancy:** _____ **Current Grade in school:** _____

Were there any problems during pregnancy or delivery? Yes / No **If yes, please describe:**

Are there any siblings with eye problems? Yes / No **If yes, please describe:**

Are there any problems at school that we should address? Yes / No **If yes, please describe:**