Welcome to Lemon Grove Optometry

Thank you for choosing our office for your eye care needs. We are pleased to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following important information. If you have questions, please don't hesitate to ask.

Name _____Birthdate _____/_____/_____ SSN _____

Address_____ Apt. # _____ City_____ State_____

Zip Code _____Home Phone_____ Work Phone_____

Cell Phone_____ Employer _____Occupation_____

Hobbies_____

E-Mail _____Marital Status _____

Who may we thank for referring you to our office? ☐ Insurance ☐ Online ☐ Patient Referral ☐ Walk-in

If patient referral, please provide his/her name _____

What is the main reason for your visit today? _____

Do you wear any Contact lenses? YES / NO If yes, please specify type/brand: _____

Do you have any of the following Medical Conditions? ***Please check all that apply.***

Anxiety	☐	Hypertension	☐
Arthritis	☐	High Cholesterol	☐
Asthma	☐	Hyperthyroidism	☐
Atrial Fibrillation	☐	Hypothyroidism	☐
Depression	☐	Seizures	☐
Diabetes	☐	HIV/AIDS	☐
GERD	☐	Other	☐

Please specify other medical conditions (*if applicable*): _____

Do you have any allergies to any <u>medications</u>? YES / NO If yes, please list: _____

Please list any **<u>current medications</u>** including over the counter medications you are taking:

Do you currently have any of the following eye conditions? ***Check the box if "Yes."***

☐ Glasses	☐ Dryness	☐ Itching	☐ Glaucoma
☐ Contacts	☐ Sandy or Gritty Feeling	☐ Redness	☐ Allergic Conjunctivitis
☐ Any Loss of Vision	☐ Burning	☐ Styes/Chalazion	☐ Cataracts
☐ Double Vision	☐ Tired Eyes	☐ Floaters	☐ Macular Degeneration

☐ Other: _____

Personal Eye Information & Social History	Y	N	Please explain
Eye Surgeries/Injury			
Headaches			
Cigarette/Tobacco/Smokeless Tobacco			

FAMILY HISTORY	Y	N	Who in your family has had the following?
Macular Degeneration			
Glaucoma			
Retinal Detachment			
Other Eye Conditions			

I acknowledge receipt of Lemon Grove Optometry's Notice of Privacy Practice

X _____ **Date completed**_____