

**Eyedare Optometric**

PATIENT INFORMATION

Dr. Chester Quan, OD  
 Dr. Christina Chang, OD  
 Malcolm Graves, ABOC

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name	First Name	M. Init	Sex	Birthdate	Age
Home Address , Apt #, City, State, ZIP					Home Phone	
Occupation/Employer Name		Email Address			Work Phone	
How did you hear about us?					Cell Phone	
Vision Insurance		Primary Member Name		Last 4 # of SSN and Birthdate		

PATIENT HISTORY

1. Primary Reason for today's exam (check all that apply)  
 Annual eye exam     Contact Lens Exam     Vision or Eye Health Problem     Other \_\_\_\_\_
2. Last complete eye exam: \_\_\_\_\_ Age of current glasses : \_\_\_\_\_
3. With your current glasses or contacts, is your distance/near vision good?     No     Yes
4. Have you had your eyes dilated before? .....  No     Yes When? \_\_\_\_
5. Is there a family history of cataracts, glaucoma, or other disease? .....  No     Yes
6. Do you have diabetes? .....  No     Yes
7. Do you have high blood pressure? .....  No     Yes
8. Are you being treated for any medical conditions?.....  No     Yes  
 Please List: \_\_\_\_\_
9. Are you currently taking any medications? .....  No     Yes  
 Please List: \_\_\_\_\_
10. Are you allergic to any medications? .....  No     Yes  
 Please List: \_\_\_\_\_
11. Have you ever had any eye infection, disease, injury or surgery? .....  No     Yes  
 Please Explain: \_\_\_\_\_
12. Have you ever had a crossed or lazy eye? .....  No     Yes
13. Do you have headaches which you think are related to your eyes?.....  No     Yes
14. What sports and/or hobbies do you enjoy? \_\_\_\_\_
15. Are you interested in new contact lenses? .....  No     Yes
16. Have you ever worn contact lenses? .....  No     Yes  
 Type of lens and Brand: \_\_\_\_\_
17. How many days per week do you wear contacts? \_\_\_\_\_ Hours per day? \_\_\_\_\_
18. Do you sleep with your contacts lenses? .....  No     Yes
19. What lens care system do you use?  Renu     Optifree     Clear Care     Boston     Other
20. Are you interested in Laser Eye Surgery? .....  No     Yes

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I have read, reviewed and understand the privacy policies of Eyedare Optometric Practice.

Print Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Parent or Guardian if under 18yrs. \_\_\_\_\_