PLEASE PRINT CLEARLY

WELCOME TO OUR OFFICE

David Baba, O.D. Date:_____

Patient: _____ Birthdate:_____ Home Ph:_____
(First) (Middle) (Last) Cell Ph:_____

Mailing Address: _____ City: _____ Zip:_____

Occupation: _____ Employer: _____ Work Phone:_____

Are you a new patient to this office? Yes _____ (★ Photo ID Required), No _____

Email: _____ Emergency Contact Name/Phone _____

Major Medical Insurance (non-vision) _____ Secondary Vision Insurance: _____

Patient's Social Security Number _____ Primary Care Physician: _____

How Did You Choose Our Office? _____Referred by a Patient/Doctor: Name _____

_____Insurance Plan _____Other _____

Vision History

If you wear glasses, how old is your most recent pair? _____ years Last Eye Examination? _____ years

What is the main reason for your visit? _____

Please circle: **Want Glasses / Contact lenses**

Please complete the following:

Yes	No		Yes	No		Yes	No	
____	____	Want Lasik	____	____	Use a Computer	____	____	Smoke, Alcohol, Drugs (OTC)
____	____	Headaches	____	____	Poor Distance Vision	____	____	Herbs, Vitamins
____	____	Double Vision	____	____	Poor Close Vision	____	____	Cataract
____	____	Floaters / Spots	____	____	Poor Night Vision	____	____	Glaucoma
____	____	Flashing Lights	____	____	Lazy Eye / Amblyopia	____	____	Hay Fever / Allergies
			____	____	Eye Injury / Surgery	____	____	Watery / Itchy Eyes
List Hobbies _____						____	____	**OTHER**

Your Medical History

Since some general body diseases / conditions affect our eyes, please complete the following:

Yes	No		
____	____	High Blood Pressure	What medications (including birth control pills) do you take? _____
____	____	Heart Disease	_____
____	____	Diabetes No. of Years ____	_____
____	____	Thyroid Disease	_____
____	____	Pregnant	What medications are you allergic to? _____
____	____	Other	_____

Date of last general health examination: _____

Family History

Since some diseases can be inherited, please check any disease / condition that your parents, grandparents, aunts, uncles, brothers, or sisters have had.

Yes	No		Yes	No		
____	____	High Blood Pressure	____	____	Cataracts	Other_____
____	____	Heart Disease	____	____	Macular Degeneration	_____
____	____	Diabetes	____	____	Eye Surgery	_____
____	____	Glaucoma	____	____	Lazy Eye / Amblyopia	_____