SOUTH BAY OPTOMETRY, Inc. **Health History and Lifestyle Questionnaire**

Whom may we thank for this referral?:

Salutation: Mr. / Mrs. / Ms. / Miss / Dr. Gender: M / F DOB: ___/___/_____

Last:_____ First:_____ Middle Initial:_____

Address:_____ Apt:_____ Home #:_____

City:_____ Zip: _____ Cell #:_____

Email Address:_____ Work #:_____

Communication preference: ◯ Cell ◯ Home ◯ Work ◯ Email ◯ Text ◯ Any Occupation:_____

Race (optional): ◯ American Indian or Alaska native ◯ Asian ◯ African American ◯ Caucasian/White ◯ Native Hawaiian or other Pacific Islander ◯ Other ◯ Decline to answer

Ethnicity (optional): ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Other ◯ Declined to answer

What is the **MAIN** reason for your visit today?:_____

Insurance Information

Vision Insurance: ◯ VSP ◯ Davis ◯ Eyemed ◯ MES

Primary Member: Last:_____ First:_____ DOB:_____ Last 4 SSN:_____

Member ID #:_____ Relationship to Primary Member:_____

Eye Information

Date of last eye exam:_____ Dilated?: Yes / No

Do you wear glasses: ◯ No ◯ Yes: Full time / Part time / Distance only / Reading only / Multifocal

How old are your glasses:_____ Do you wear sunglasses: ◯ No ◯ Yes

Do you wear contacts: ◯ No ◯ Yes If yes, what are they called?:_____

How often are they replaced?:_____ Do you want to improve their comfort?: ◯ No ◯ Yes

Are you interested in overnight contacts to correct your daytime vision? ◯ No ◯ Yes

Do you have eye fatigue on the computer? ◯ No ◯ Yes After how many hours?:_____

Do you have any eye conditions or problems? ◯ No ◯ Yes What kind?_____

Have you had any eye operations? ◯ No ◯ Yes Type:_____ Date:_____

Have you had any eye injuries? ◯ No ◯ Yes Type:_____ Date:_____

Have you had any head trauma? ◯ No ◯ Yes Type:_____ Date:_____

Have you or a family member been diagnosed with any of the follow eye problems?

	Self	Family member		Self	Family member
Cataract	◯	◯_____	Macular Degeneration	◯	◯_____
Crossed Eyes	◯	◯_____	Retinal Detachment	◯	◯_____
Glaucoma	◯	◯_____	Dry Eye	◯	◯_____
Lazy Eye	◯	◯_____	Other:_____	◯	◯_____

(Turn over)

Medical History

Last physical/medical exam:_____ Name of physician:_____

Medications (Please include over the counter or herbal medication/supplement, eye drop, vitamin, and contraceptive):

_____

Allergies to medications/environmental triggers?: _____

Do you smoke tobacco? Yes / No How many years?:_____

Do you drink alcohol? Yes / No Do you use recreational drugs? Yes / No

Please check beside any problem that you or family member have or have had:

	Self:	Family member:
CARDIOVASCULAR		
Heart Disease	◯	◯_____
High Blood Pressure	◯	◯_____
High Cholesterol	◯	◯_____
EAR, NOSE, MOUTH,THROAT		
Sinus Congestion	◯	◯_____
Dry Throat / Mouth	◯	◯_____
ENDOCRINE		
Diabetes	◯	◯_____
Thyroid Disease	◯	◯_____
GASTROINTESTINAL		
IBS / Crohn's Disease	◯	◯_____
Ulcers	◯	◯_____
Reflux	◯	◯_____
GENITOURINARY		
Kidney Disease	◯	◯_____
Ovarian / Uterine Cancer	◯	◯_____
Prostate Cancer	◯	◯_____
HEMATOLOGIC / LYMPHATIC		
Anemia	◯	◯_____
Breast Cancer	◯	◯_____

	Self:	Family member:
INTEGUMENTARY (Skin)		
Cancer	◯	◯_____
Easy Bruising	◯	◯_____
MUSCULOSKELETAL		
Rheumatoid Arthritis	◯	◯_____
Muscle Pain	◯	◯_____
Joint Pain	◯	◯_____
NEUROLOGICAL		
Migraines	◯	◯_____
Seizures	◯	◯_____
Stroke/Brain Injury	◯	◯_____
PSYCHIATRIC		
Anxiety	◯	◯_____
Depression	◯	◯_____
Memory Loss	◯	◯_____
Hallucinations	◯	◯_____
RESPIRATORY		
Asthma	◯	◯_____
Bronchitis	◯	◯_____
Emphysema	◯	◯_____
OTHER:_____	◯	◯_____

____ Please initial if you agree: I understand that I am responsible to pay for all services rendered by this office at the time it is rendered. I also understand that in the event my insurance does not pay for the billed services, I will be responsible for the payment of the services in a prompt manner.

____ Please initial if you agree: I have read the South Bay Optometry Privacy Notice and understand my rights contained therein. By way of my signature, I acknowledge that South Bay Optometry has provided me with a policy regarding the use and disclosure of my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. A copy shall be as valid as the original.

____ Please initial if you agree: I give consent that South Bay Optometry may use photographs or videos of me, taken on the date below, on their social media tools which include but is not limited to their Facebook and Instagram page. I understand that these images and/or videos will not be used for any other commercial purposes. Your identifying information will not be disclosed.

Print Patient Name (parent/guardian if minor):_____

Signature:_____ Date:_____