SOUTH BAY
OPTOMETRY

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Health History and Lifestyle Questionnaire

Patient Information

Full Name: _____ Date of Birth: ___ /____/____ Male Female
Home Address: _____
Phone: _____ Cell, home, or work? _____
Email Address: _____
Communication Preference: Phone Text Email Any
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____
Date of last physical/medical exam: _____ Name of physician: _____
Occupation: _____ Employer: _____
What is the MAIN reason for your visit today? _____

Insurance Information

Vision Insurance: VSP Davis EyeMed MES
Primary Member (Last name, First Name): _____ DOB: ___/___/___
Member ID #: _____ Relationship to Primary Member: _____ Last 4 SSN: _____

Eye Information

Date of last eye exam: _____ Were your eyes 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: Yes No
Do you wear contact lenses: No Yes : If yes, what brand/name?: _____
Do you have eye fatigue after using the computer? No Yes : After how many hours? _____

Sports and Leisure

What hobbies/sports do you participate in? _____
Do you wear any special eyewear or contact lenses for your hobby/sport? _____

Social History

Do you smoke tobacco? No Yes : How many years? _____; How many cigarettes per day? _____
Do you drink alcohol? No Yes
Do you use recreational drugs? No Yes

Please check boxes that apply. Unchecked boxes will mean "no"

Personal Eye History

Conditions	YES	Surgeries	YES
Glaucoma/ Suspect		Cataract	
Cataract		Glaucoma	
Macular degeneration		Retinal tear	
Uveitis		LASIK	
Retinal tear or detachment		Laser	
Eye turn/Lazy Eye		Eyelid	
Trauma		Injections in eye	

Personal Medical History

	YES		YES
Diabetes		Concussion	
High blood pressure		Stroke	
Elevated cholesterol		Heart attack	
Thyroid disorder		Arthritis	
Sleep apnea		Kidney disease	
Pregnant - currently		Cancer	
Nursing - currently		Other:	

Family History

Ocular	YES	Medical	YES
Glaucoma		Diabetes	
Eye turn/Lazy eye		Hypertension	
Macular degeneration		Cancer	
Night blindness		Heart Disease	
Keratoconus		Migraine	
Other:		Other:	

Review of Systems

	CURRENT SYMPTOMS	YES
Constitutional	Unexplained fever	
	Unexplained weight loss	
	Unexplained fatigue	
Cardiovascular	Chest pain	
	Shortness of breath with exertion	
	Irregular heart beat	
	Low heart rate	
Endocrine	Increase in urination	
	Increase in thirst	
	Increase in appetite	
Gastrointestinal	Constipation	
	Diarrhea	
	Unexplained abdominal pain	
Genitourinary	Burning while urinating	
	Difficulty urinating	
	Blood in urine	
Head	Persistent sore throat	
	Hearing loss	
	Ear or nose discharge	
	Loss of smell	
	Sinus congestion	
	Difficulty swallowing	
Hematologic/ Lymphatic	Swollen glands	
	Anemia	
	Frequent bruising	
Immunologic/ Integumentary (skin)	History of infectious disease	
	Unexplained skin rashes	
	Persistent itching of skin	
	Eczema of skin	
	Pigmented lesions	
Musculoskeletal	Joint pain	
	Unexplained muscle pain	
	Lower back pain	
Neurologic	Muscle weakness	
	Tingling in extremities	
	Dizziness	
	Blackouts/grey outs	
Psychiatric	Ongoing depression	
	Disorientation	
	Dementia	
Respiratory	Shortness of breath	
	Persistent cough	

Allergy

Allergen	YES
Seasonal	
Penicillin	
Sulfa	
Neomycin	
Anesthetic or “-caine” drug	
Food:	
Other:	

Medications

Name	Dose	Purpose

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.

___ 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.

___ I give consent that South Bay Optometry may use photographs or videos of my eyes and/or ocular structures, taken on the date below, on their social media tools which include but are 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.

I verify that the information contained on this page is current and without changes.*

Patient or Parent/Guardian Signature Date

☐ ** Click or check box to agree that the electronic signature appearing in this document is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.*