CENTURY CITY OPTOMETRIC CENTER

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10390 Santa Monica Blvd. Suite 320, Los Angeles, CA 90025
(Adult)

Patient's Name:_____ **Date:** _____

Date of Birth:_____ **Age:**_____ **Sex: M F**

Occupation:_____

What is your main reason for coming here today? _____

_____

Are your symptoms due to an accident? Please explain. _____

Are there times when your vision (or present lens) isn't quite right?_____

Are there any activities you would enjoy, yet are restricted because of your vision? _____

VISION HISTORY

Date of your last eye examination:_____
Do you wear glasses now? Y N _____ for distance only _____ for near only _____ full time
Have you ever worn glasses? Y N
Do you wear contacts lenses? Y N
Are you having any problems with your contact lenses? _____
Have you ever been told you can't wear contact lenses? Y N
Have you ever had vision therapy? Y N

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

	Me	Family		Me	Family
Allergies	☐	☐	Dry Eyes	☐	☐
Cancer	☐	☐	Cataracts	☐	☐
Drug Sensitivity	☐	☐	Eye Strain	☐	☐
Diabetes	☐	☐	Floaters/Spots	☐	☐
High Blood Pressure	☐	☐	Light Sensitivity	☐	☐
Elevated Cholesterol	☐	☐	Eye Surgery	☐	☐
Migraine/headaches	☐	☐	Turned eye	☐	☐
Thyroid	☐	☐	Lazy Eye	☐	☐
Heart Problem	☐	☐	Flashing Lights	☐	☐
Respiratory Disease	☐	☐	Retinal Detachment	☐	☐
Head Trauma	☐	☐	Glaucoma	☐	☐
Blindness	☐	☐	Color Blindness	☐	☐

How is your general health? _____ Date of last physical: _____
Are you currently under a physician's care? Y N
Are you regularly taking pills or medications? Y N Please Specify_____
Allergies to Medications: _____

(continue on other side)

VISUAL DEMANDS AT WORK

What activities do you do at work? (circle all that apply)

Typing	Accounting	Deliveries
Computer	Writing/editing	Sales
Inspecting	Driving	Monitor Instruments
Data Entry	Loading	Other: _____

Do you use a computer on your job? Y N Hours per day _____
Do you use a computer at home? Y N Hours per day _____
Do letters "swim"? Y N
What lenses do you wear for the computer? _____ Glasses _____ Bifocals _____ Contact Lenses
When using the computer, do your eyes get: _____ Red _____ Dry _____ Ache
Do you feel pain in your: _____ Neck _____ Shoulder _____ Back

Do you experience any of the following discomfort at work? (circle all that apply)

Headaches	Eye strain	Get sleepy
Letters blur as you read	Eyes red or watery	Lose your place often
Occasionally see double	Pulling sensation near eyes	Avoiding certain tasks

Does it take increasing effort to see clearly as the day wears on? Y N
Do you hunch closer to your work by the end of the day? Y N
Do street signs blur as you drive home from work? Y N
Is it difficult to bring print or objects to clear focus? Y N If yes, when?_____
Do you find it hard to proofread/find errors when computing? Y N

RECREATION AND LEISURE

In what recreational activities do you participate? (Circle all that apply)

Read	Basketball	Flying
Racquetball	Swim	Video games
Tennis	Camp	Musical instruments
Golf	Sew	Other: _____
Baseball	Play cards	

Do you wear protective eyewear for your sport? Y N
What are you doing to protect your eyes from ultraviolet exposure? _____
Does your vision, or do your lenses, interfere with enjoyment of your activities? _____
Television: Is viewing ever uncomfortable? Describe the discomfort._____
Do you recline while viewing? Y N
Do your lenses work well for T.V.? Y N

Thank you for your help. The information in this personal history form is critical to the evaluation of your vision.