Fortuna Optometry

630 9th Street Fortuna, C.A. 95540
(707) 725-5144

NAME:_____ Sex: M / F DOB_____ SS#_____

Address:_____City_____State_____Zip_____

Phone#_____Work#_____Cell#_____Email:_____

Employer:_____ Occupation:_____

Spouse or Legal Guardian:_____ Last Eye Exam_____

Last Medical Exam_____Name of Medical Doctor_____Phone#_____

Vision Insurance:_____Medical Insurance:_____ID#_____

FAMILY HEALTH HISTORY

Please indicate immediate family members with: M=Mother F=Father B=Brother S=Sister

- ☐Blindness
- ☐Cataract
- ☐Crossed Eyes
- ☐Diabetes

- ☐Glaucoma
- ☐Macular Degeneration
- ☐Retinal Detachment
- ☐Cancer

- ☐Heart Disease
- ☐High Blood Pressure
- ☐Lupus
- ☐Arthritis

- ☐Thyroid Disease
- ☐None
- ☐Other:_____

PATIENT'S OCULAR/ MEDICAL HISTORY

Do you have any allergies to medications? _____Yes ____No. If yes, please list_____

List all the **medications** you are currently taking:_____

_____Pharmacy:_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

Are you pregnant and/or nursing?	____Yes	____No	Are you sensitive to light?	____Yes ____No
Do you wear glasses?	____Yes	____No	If yes, How old is your current pair of glasses? _____
Do you wear contact lenses?	____Yes	____No	Type of contact lenses:_____
Are you interested in contact lenses?	____Yes	____No	

Please check any conditions that you have or have had in the past:

- ☐Blurred Vision
- ☐Loss of Vision
- ☐Double Vision
- ☐Redness
- ☐Crossed Eyes
- ☐Lazy Eye
- ☐Eye Surgery
- ☐Cataract
- ☐Retinal Detachment
- ☐Flashes/Floaters

- ☐Macular Degeneration
- ☐Glaucoma
- ☐Pain
- ☐Headaches
- ☐Excessive Tearing
- ☐Dryness
- ☐Itching/Burning
- ☐Mucus Discharge
- ☐Eye Injuries
- ☐Eye Infection/Redness

- ☐Diabetes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Dizziness
- ☐Stroke
- ☐Seizure
- ☐Migraine
- ☐Spots
- ☐Night Blindness
- ☐Asthma

- ☐Thyroid
- ☐Cancer
- ☐Arthritis
- ☐Anemia
- ☐Anxiety/Depression
- ☐Sinus Congestion
- ☐Emphysema
- ☐None
- ☐Other:_____

If you checked a box above or have a condition not listed, please explain: _____

SOCIAL HISTORY

Do you use tobacco products?	____YES	____NO	(If yes) type/ amount/ how long:_____
Do you drink alcohol?	____YES	____NO	(If yes) type/ amount/ how long:_____
Do you use recreational drugs?	____YES	____NO	(If yes) type/ amount/ how long:_____

Have you ever been exposed to or infected with: _____ Gonorrhea _____Hepatitis _____HIV _____Syphilis
Referred by? _____
Hobbies_____

NOTICE OF PRIVACY

Acknowledgement of Receipt of Privacy Notice(HIPPA)
By signing below, I acknowledge that I have read/receive the copy of the Notice of Privacy Practices for review.

_____   _____
(Patient's Signature or Legal Representative)   (Date)