Dr. Sophie K. Dao

Welcome To Our Optometry Center

Patient Check in Form

For faster service, please complete the following form prior to arriving at our office.

Patient's Name (please print) ______

If a Child, Parent's Name ______

Patient's Date of Birth ______ M or F ______ Social Security # ______

Street Add: ______ City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______ Work Phone ______

E-mail Add ______

Employer ______ Occupation ______

Health Insurance ______ Policy # ______

Medicare/Medicaid ______ Policy # ______

Date of Last Eye Exam ______

What is the main reason for today's visit? ______

When was your last physical exam, including blood work? ______

Do you currently wear glasses?

- ☐ No
- ☐ Yes, Since ______

What type of glasses do you currently own?

☐ Full Time ☐ Distance ☐ Computer ☐ Single Vision ☐ Progressive

☐ Part Time ☐ Close ☐ Bifocals ☐ Trifocal ☐ Prescription Sunglasses

Do you currently wear contact lenses?

- ☐ No, Are you interested in trying contact lenses at this time? ☐ No ☐ Yes
- ☐ Yes, Since ______

Do you use nutritional supplements? ☐ No ☐ Yes

Do you engage in regular exercise? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes, how much/often ______

Do you smoke? ☐ No ☐ Yes how much/often ______

Are you in good health?

☐ Yes ☐ No, please write the problem

Any allergic reactions to medications or other substances?

☐ No

☐ Yes, please list

Do you take medications?

☐ No

☐ Yes, please list

Do you have history of any of the following? If Yes, please check box.

☐ Glaucoma	☐ Cataract	☐ Retinal Detachment	☐ Macular Degeneration
☐ Color Blindness	☐ Headaches	☐ Burning	☐ Glare/Light Sensitivity
☐ Tired Eyes	☐ Dryness	☐ Excess Tearing	☐ Amblyopia (lazy eye)
☐ Eye Pain	☐ Itching	☐ Mucous Discharge	☐ Infection of Eye or Lid (stye)
☐ Drooping Eyelid	☐ Redness	☐ Fluctuating Vision	☐ Sandy or Gritty Feeling
☐ Double Vision	☐ Distorted Vision	☐ Blurred Vision Near	☐ Blurred Vision Distance
☐ Floaters or Spots	☐ Loss of Vision	☐ Loss of Side Vision	☐ Strabismus (eye turn)

Do you have family history of any of the following? If Yes, please check box.

☐ Blindness	☐ Cataract	☐ Retinal Detachment
☐ Glaucoma	☐ Arthritis	☐ Amblyopia (lazy eye)
☐ Color Blindness	☐ Cancer	☐ Macular Degeneration
☐ Diabetes	☐ Heart Disease	☐ Strabismus (eye turn)
☐ Kidney Disease	☐ Lupus	☐ High Blood Pressure

Do you have any of the following problems? If Yes, please check box.

☐ Fever	☐ Weight Loss	☐ Respiratory
☐ Ears, Nose, Throat	☐ Cardiovascular	☐ Gastrointestinal
☐ Kidney, Bladder	☐ Endocrine	☐ Muscles, Bones, Joints (arthritis)
☐ Psychiatric	☐ Allergic/Immunologic	☐ Skin (acne, skin cancer, etc.)
☐ Infections	☐ Thyroid Disease	☐ Neurological (multiple sclerosis)

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature ______________________ Date ______________________

Thank you for taking the time to help our office personalize your eye care. Your answers will help guide us to your specific needs. We look forward to seeing you for your examination. Please feel free to let us know if you have any other concerns we have not addressed.