

GRIFFIN OPTOMETRIC GROUP

San Clemente □ *Laguna Niguel* □ *The Courtyards at Talega*

We welcome you to our offices. The following vision and health information is requested to help us give you a complete and thorough vision exam. All information is kept private.

Name _____ Today's Date: ____/____/____
Address: _____ Primary Phone: _____
_____ 2nd Phone: _____
Email : _____ Guardian (If applicable): _____

Birth Date: ____/____/____ Occupation: _____ Last Eye Exam: ____/____/____
Do you have Vision Insurance: (circle one) VSP Safeguard Other _____
Primary Insured's Info: Name: _____ Last 4 SS# _____ Date of Birth ____/____/____
Name of Medical Doctor: _____ Last Medical Exam: ____/____/____
Medical Insurance: HMO PPO POS None Insurance Company: _____

What is the purpose of today's visit? _____
Are you experiencing any of the following: Distance Blur Reading Blur Eyestrain
Do you work at a computer for long periods? yes no Do you have prescription sunglasses? yes no
Do you have problems w/nighttime glare? yes no Are you interested in contacts? yes no
Do you have dry, burning or stinging eyes? yes no Would you like information on LASIK? yes no
How did you hear about us? Friend/Relative/Another Healthcare Practitioner Who? _____

MEDICAL HISTORY

Do you have any allergies to medications? yes no If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, antidepressants, over the counter medications , vitamin supplements): _____

List all major injuries, surgeries and /or hospitalizations you have had in the past year: _____

Please check any of the following that you have had: glaucoma cataracts retinal disease/detachment
 eye infections eye injury crossed eyes drooping eyelid lazy eye arthritis macular degeneration
Are you pregnant and/or nursing? yes no
Do you wear glasses? yes no If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? yes no If yes, how old is your present pair of lenses? _____
Type of contact lenses? Rigid Soft Extended Wear Other Are they comfortable? yes no

FAMILY HISTORY

Please note any family history (parents/grandparents/siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITIONS	YES	NO	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two

FAMILY HISTORY (continued)

DISEASE/CONDITIONS	YES	NO	?	RELATIONSHIP TO YOU
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

All information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History directly with my doctor. (check box)

Do you drive? yes no If yes, do you have visual difficulty when driving? yes no If yes, please describe:

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 illegal drugs? yes no If yes, type/amount/how long? _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas?

SYSTEM	YES	NO	?	YES	NO	?
NEUROLOGICAL				EARS, NOSE, MOUTH, THROAT		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
EYES				Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Distance Blur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Reading Blur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Eyestrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR		
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES		
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Abrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to any of the above or have a condition not listed, please explain:

I hereby authorize the release of any medical information necessary to notify my family physician and/or process an insurance claim. I understand I am responsible for any charges not covered by my insurance .

Patient Signature

Print Name

Date