Dr. Alex Corbin Liu, Dr. John Nelson, Dr. Phillip Endicott

This questionnaire is to be reviewed at each appointment

Today's Date_____ Male_____ Female_____

Last Name_____ First Name_____

Address_____ City_____ State_____ Zip_____

Cell Phone (_____)_____-_____ Home Phone (_____)_____-_____

Email _____ SSN#_____

DOB_____/_____/_____ Occupation_____ Employer_____

Emergency Contact Name/Number_____/ (_____)_____-_____

Date of Last Eye Exam_____/_____/_____ Dilated Yes/No Referred By_____

Vision Coverage? Yes/No _____ Secondary Coverage_____

MEDICAL INFORMATION

Do you take medications or have a medical Issue for any of these systems? (Please check yes or no)

	Yes	No		Yes	No		Yes	No
Gastrointestinal	___	___	Nervous	___	___	Endocrine (glands)	___	___
Ears/Nose/Throat	___	___	Urinary	___	___	Blood/Lymph	___	___
Cardiovascular	___	___	Muscles/Bones	___	___	Allergic/Immunologic	___	___
Respiratory	___	___	Integumentary (skin)	___	___	Headaches	___	___
High blood pressure	___	___	Mental	___	___	Diabetes	___	___

If answered Yes to any of the above, please explain_____

Allergies to medication Yes/No Which?_____

Other health concerns_____

Current medication(s)_____

Have you had any operations? Yes/No Type_____ Date _____

Name of family doctor and/or primary care physician_____

FAMILY HISTORY

High blood pressure Yes/No Relation_____ Macular degeneration Yes/No Relation_____

Diabetes Yes/No Relation_____ Retinal detachment Yes/No Relation_____

Glaucoma Yes/No Relation_____ Cataracts Yes/No Relation_____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes/No_____

Eye operations? Yes/No_____ Date_____ Eye injury? Yes/No_____ Date_____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No Blurred vision? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type_____

Please read the following and sign below after reading

- *To release a contact lens prescription the doctor must perform a contact lens evaluation which is subject to a fee. California State law requires all optometrists to perform a contact lens examination and fitting each and every year. Contact lenses are a medical device and can cause harm or blindness if misused. To ensure we are in accordance with state law we must perform the additional examinations to ensure your safety and the efficacy of the contact lens prescription.* _____

- Due to the custom made nature of your eyewear, we are unfortunately unable to provide refunds or re-styles on a frame and lens purchase that is later to be found unsatisfactory. If there is an issue with the performance of your vision, please be assured we will do our best to accommodate your concern.
  - Please be aware of this policy when making your eyewear decision. To the best of our abilities we will help you make the best choice for your needs. _____

- We are more than happy to fit your new prescription lenses into your previously worn frame. Frames that were either not purchased at this establishment or are over one year old cannot be warrantied against any damage or breakage that may occur. The doctors, opticians and our optical laboratoty personel always give the utmost care of all frames. Although rare, frames can and will break and unfortunately we cannot be held liable for these frames. _____

Signature:_____ Date:_____

Reviewed

Initials: _____ _____ _____ _____ _____ _____ _____

Date: _____ _____ _____ _____ _____ _____ _____

Initials: _____ _____ _____ _____ _____ _____ _____

Date: _____ _____ _____ _____ _____ _____ _____

For Office Use Only

Initials: _____ _____ _____ _____ _____ _____ _____

Date: _____ _____ _____ _____ _____ _____ _____

Initials: _____ _____ _____ _____ _____ _____ _____

Date: _____ _____ _____ _____ _____ _____ _____