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

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