Oroville Vision Optometric Group

Patient History Form

Patient Information

Today's Date: _____ Birth Date: _____

Last Name: _____ First Name: _____ MI _____ Male/Female

Address: _____ City: _____ State: ___ Zip: _____

Preferred Phone: (___)_____ Other Phone: (___)_____ Primary Care Physician: _____

Emergency Contact: _____ Phone: _____ Referred By: _____

Preferred Language: _____ SSN: _____

Employer (or School): _____ Occupation (or Grade): _____

Email: _____ Signature: _____

Insurance Information

Plan Name: _____ Group: _____ Insured ID #: _____

Insured Name: _____ Insured DOB: ___/___/___ Relationship to Patient: Self/Spouse/Child

Appointment Information

Reason for exam? _____

Are you planning to get new glasses today? Yes/No Previous Patient? Yes/No Date of Last Eye Exam ___/___/___

Have you ever worn contact lenses? Yes/No Are you planning to get new contact lenses today? Yes/No

Age of Current Glasses _____ Age of Sunglasses _____ From Provider _____

Medical & Ocular History

Do you or any of your relatives have any of these conditions?

	Self	Relative		Self	Relative
Diabetes	☐	☐	Cataracts	☐	☐
High Blood Pressure	☐	☐	Retinal Disease	☐	☐
Thyroid Problems	☐	☐	Macular Degeneration	☐	☐
Heart Disease	☐	☐	Glaucoma	☐	☐
Eye Surgery	☐	☐	Eye Injury	☐	☐
Asthma	☐	☐	Other _____	☐	☐

Eyes have been dilated? Y/N Year: _____ Are you pregnant? Y/N Frequent headaches? Y/N

Are you taking any eye drops (Prescription or Over the Counter)? Please list.

_____

Are you taking any other medications (prescription or over the counter)? Please list.

_____

Do you have any allergies, medication or other? If yes, please explain.

_____