See-Kleer Eyecare Center

9580 Black Mountain Rd., Suite J
San Diego, Ca. 92126
(858) 536-8952

DATE: _____

Name:_____ Date of Birth:_____ Age:___
Social Sec. No._____-____-_____ Home Phone: _____ Work Phone:_____
Address: _____ City: _____ State: _____ ZIP: _____
Occupation:_____ Employer: _____ Hobbies: _____
Emergency Contact tel. No: _____ Who may we thank for referring you?_____
E-mail address: _____ @_____ . _____ Preferred Payment method: Cash?___ check?___
Insurance: Vision:_____ Health/Medical: _____ Group Id No: _____
Date of Last Eye exam: _____ Dilated? Y/N By DR? _____
Briefly describe the reason for your eye examination: _____
_____
_____

Do You have: (please circle)
Eyestrain Eye pain Double vision Floaters Flashes of light Eye disease: Kind? _____

PATIENTS and FAMILY MEDICAL INFORMATION:

How is your general health?_____
Do you or any blood relatives (grand parents, parents, brothers, sisters, children) have (please check & indicate)

	Self	Blood Relative		Self	Blood Relative		Self	Blood Relative
( ) Arthritis	( )	( )_____	( ) High Cholesterol	( )	()_____	( ) Glaucoma	( )	()_____
( ) Asthma	( )	( ) _____	( ) Heart disease1	( )	()_____	( ) Cataract	( )	()_____
( ) Kidney disease	( )	( ) _____	( ) Thyroid	( )	() _____	( ) Retinal Detach	( )	()_____
( ) Hypertension	( )	( ) _____	( ) Lung disease	( )	()_____	( ) Eye turn	( )	()__ _____
( ) Diabetes	( )	( ) _____	Type: _____		(Self: Date of Diagnosis:_____			

List current medication: _____
List ALLERGY to any medication: _____
Do you experience DRY eyes or ITCHY eyes? Y/N Do you currently use eye drops for relief? Y/N , If yes, how long does the relief last?_____ No. of drops/day?_____ Name of eyedrop?__ _____
Do you use cigarettes/tobacco? Y/N_____ Alcohol? Y/N_____ Other substance? Y/N _____
Name of your Primary Physician: _____ Date of last visit/physical: _____
Have you had any surgery? Y/N: Kind? _____ When? _____
Date of last tetanus shot: _____ Are you pregnant? Y/N: Trimester? _____
Do you work in front of computer? Y/N: How long? _____ Do you have advance directive for healthcare? Y/N
Do you have problems with any of these systems?

Eyes	Y/N	Genitourinary	Y/N	Integumentary(skin)	Y/N	Respiratory	Y/N
Mental	Y/N	Gastrointestinal	Y/N	Ears/Nose/throat	Y/N		
Nervous	Y/N	Cardiovascular	Y/N	Allergic/immunologic	Y/N		
Blood/Lymph	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N		

Please explain: _____

I authorize payment of healthcare benefits to this office. I understand that I am responsible for payment of any charges not covered by my insurance.

_____
Signature (patient, parent, guardian)

' UNCORRECTED		Habitual Correction: CL / Specs	BC:/ O.Z	DIA	' CORRECTED	
DISTANT	NEAR		ADD	PRISM	DISTANT	NEAR
OD: 20/	20/				OD: 20/	20/
OS: 20/	20/				OS: 20/	20/

P.D. _____ Seg ht OD.:_____ O.S.: _____ Multifocal type: Bifocal Trifocal PAL No line-bifocal