North Torrance Optometry
Patient Diagnostic Form

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Torrance, CA 90504
310-532-8900

Date_____ Dr. / Mr. / Mrs. / Ms. / Miss

Last Name_____ First Name_____ MI____Gender: Male / Female

Last 4 digits of SSN__XXX-XX-_____ Date of Birth _____/_____/_____ Age _____

Home Address _____

City_____State_____Zip_____

Primary Phone #_____Home/ Cell/ Work Secondary Ph#_____Home/ Cell/ Work

Other Phone # _____Home/Cell/Work May we contact you by text message? Yes / No

May we contact you by e-mail Yes / No E-Mail Address_____

Employer_____Occupation_____

Name of Spouse (Name of parent/guardian if minor)_____

Emergency contact_____ Phone Number _____ Relationship_____

Are you a new patient? Yes / No If yes, how were you referred to us _____

Do you have **VISION** insurance? Yes / No If yes, which one_____

Do you have **MEDICAL** insurance? Yes / No If yes, which one_____ HMO / PPO

PERSONAL EYE HISTORY

Date of last eye examination_____Name of last Optometrist/Ophthalmologist_____

Are you currently under the care of an Ophthalmologist? Yes / No If yes, explain_____

Have you had eye surgeries/injuries? Yes / No If yes, explain_____

Do you experience any problems with your current eyewear? Yes / No If Yes, explain_____
Do you have up-to-date back-up glasses? Yes / No
Do you have problems with glare or reflections? Yes / No
Do you spend a lot of time outdoors? (ex: gardening, walking) Yes / No
Do you work on the computer for long periods? Yes / No
Do you have any questions regarding LASIK eye surgery? Yes / No
Do you wear contact lenses? Yes / No If yes, what type_____

List the sports and hobbies you participate in _____

PATIENT HEALTH HISTORY

Date of last medical examination_____Name Primary Care Physician_____

MEDICAL / FAMILY HISTORY
List any medications you take (include oral contraceptives, vitamins and over the counter meds)_____

_____

_____

Do you have any allergies? Yes / No If yes, explain_____

Do you have any allergies to medication? Yes / No If yes, explain_____

_____

List all major injuries, surgeries and/or hospitalizations you have had_____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

Disease / Condition	**Yourself**	**Family Member**	**Relationship (Blood Relatives Only)**
Blindness	Yes / No	Yes / No	_____
Eye Turn	Yes / No	Yes / No	_____
Glaucoma	Yes / No	Yes / No	_____
Macular Degeneration	Yes / No	Yes / No	_____
Retinal Detachment	Yes / No	Yes / No	_____

Other:_____

Women- Are you nursing and/or pregnant? Yes / No

REVIEW OF SYSTEMS

Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic	**Ear, Nose and Throat**	**Gastrointestinal**	**Skin/Integumentary**	**Psychiatric**
None	None	None	None	None
Lupus (SLE)	Sinusitis	Crohn's Disease	Eczema	Depression
Rheumatoid Arthritis	Upper Respiratory	Colitis	Rosacea	Bi-Polar
Environmental Allergies	Tract Infection	Acid Reflux / Ulcer	Psoriasis	Schizophrenia
Other (i.e., Latex)				

Cardiovascular	**Endocrine/Glands**	**Respiratory**	**Muscle/Skeletal**	**Genital/Urinary**
None	None	None	None	None
High Blood Pressure	Diabetes	Asthma	Arthritis	Urinary Tract Infection
Heart Disease	Hormone Dysfunction	Bronchitis	Fibromyalgia	HIV Positive
Stroke	Thyroid Dysfunction	Emphysema	Ankylosing Spondylitis	Herpes/Chlamydia
Vascular Disease	Other	Other	Other	Other
High Blood Cholesterol				

Hematologic/Lymphatic	**Neurological**	**General Health**	**Social**
None	None	None	Tobacco Use:
Anemia	Multiple Sclerosis	Weight loss/gain	Current Smoker / Former Smoker / Non Smoker
Leukemia	Epilepsy	Fever	Alcohol Consumption:
Bleeding Disorder	Tremors	Fatigue	None / Social Use Only / 1or more Drinks Daily
Other	Other	Trauma	Other Substances? Yes / No

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's Initials: _____

History Reviewed Date: _____ Patient Initials_____ Dr. Initials_____

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History Reviewed Date: _____ Patient Initials_____ Dr. Initials_____