eyes on gough
OPTOMETRY
235 Gough Street, SF, CA 94102
p 415.431.3100 f 415.431.1010

Please take a moment to answer the questions on this form.
THIS INFORMATION WILL BE KEPT IN STRICT CONFIDENCE.

Date ______________________

Full Legal Name ____ he/she/they

Preferred Name/Nickname ______________________________ Birthdate ______/______/______

Address ______________________________ Apt # ______ Home Phone (____) ______________

City ____________________ State ______ Zip Code __________ Work Phone (____) ______________

Occupation ______________ Employer ______________ Cell Phone (____) ______________

Email ______________________________ SSN # (last 4 digits only) __________

I give permission to receive cell phone texts for non-medical containing info, ie appt reminders & office messages: Yes No

How did you hear of our office: Insurance Internet Live/work nearby Referred by friend/family: ______________

Name of Primary Care Doctor ______________________________ Phone (____) ______________

PERSON RESPONSIBLE FOR BILL Spouse Parent Guardian Other *(Complete only if not self)*

Name ____ SSN # (last 4 only) __________

Address ____________________ City __________ State ______ Zip __________ Cell (____) __________

Occupation of Responsible Party ______________ Employer ______________ Work (____) __________

VISION PLAN AND MEDICAL INSURANCE INFORMATION (Indicate Primary and Secondary as applicable)

	ID#	Member's Name	Effective Date
☐ Vision Service Plan (VSP)			
☐ Medical Ins (HMO/PPO): ______________			
☐ Medicare			

PLEASE COMPLETE THE FOLLOWING

Are you currently having problems with your eyes or vision? Yes No

If yes, please explain: ____

____

Last complete eye examination: ______________________

Are you interested in: ☐ Eyeglasses ☐ Sunglasses ☐ Contact Lenses ☐ Lasik ☐ Orthokeratology

Do you have or have you ever had:

☐ Glaucoma ☐ Lazy Eye ☐ Crossed Eyes ☐ Cataracts ☐ Retinal Disease ☐ Eye Infections
☐ Eye Surgery ☐ Eye Injury ☐ Prominent Eyes ☐ Other **☐ None of the above**

Are you currently pregnant or nursing? ☐ No ☐ Yes ☐ N/A

Have you had any major injuries, surgeries or hospitalizations? ☐ No ☐ Yes: ______________________________

~ continued on the back ~

MEDICAL HISTORY (cont'd)

Any OTC and/or prescription MEDICATIONS you are taking (including eyedrops, vitamins)? ☐No ☐Yes:

____

____

Do you have any ALLERGIES to medications: ☐No ☐Yes: If yes, which ones: ________________________

Sex assigned at birth: ☐M ☐F

Do you presently have or have had frequent problems with any of the following:

EYES ☐ **None of the below**

☐Loss of Vision	☐ Double Vision	☐ Redness	☐Eye Pain/Soreness
☐Blurred Vision	☐ Dryness/Burning	☐ Itching	☐Chronic Infection of Eye or Eyelid
☐Tired Eyes	☐ Sandy/Gritty Feeling	☐ Excess Tearing	☐Styes or Chalazion
☐Distorted Vison	☐ Mucous Discharge	☐ Glare/Light Sensitivity	☐Flashes/Floaters

SYSTEMIC ☐ **None of the below**

☐Headaches/Migraines	☐Diabetes I or II	☐ Asthma	☐Heart Pain	☐Rheumatoid Arthritis
☐Seizures	☐ High Blood Pressure	☐ Bronchitis	☐Muscle Pain	☐Constipation
☐Head Injuries	☐ High Cholesterol	☐ Thyroid	☐Joint Pain	☐Diarrhea
☐Anemia	☐ Kidney/Bladder	☐ Allergies/Hay Fever	☐Fever	☐Psychiatric
☐Bleeding Problems	☐ Skin Condition	☐ Sinus Problems	☐Weight Loss/Gain	☐Sleep apnea

If you answered YES to any of the above or have a condition not listed, please explain: ____________________

____

____

____

____

SOCIAL HISTORY

Do you drive?	Yes	No	Do you have difficulty seeing when driving? Yes No
Do you smoke / vape?	Yes	No	Tobacco Cannabis
Do you drink alcohol?	Yes	No	# drinks per week: ________
Do you use illegal substances?	Yes	No	Type: ________________

Hobbies ____

FAMILY HISTORY

Do any of your immediate blood relatives (parents, grandparents, siblings, children) have any of the following:

☐ Blindness	☐ Crossed Eyes	☐ High Blood Pressure	☐ Diabetes
☐ Retinal Problems	☐ Glaucoma	☐ Thyroid Probs	☐ Heart Disease
☐ Macular Degeneration	☐ Cataracts	☐ Cancer/Type: ____________	
☐ Other: ______________		☐ **None of the above**	

Welcome to our office!

OFFICE USE
Doctor's signature ________________________________ Date ________________
Reviewed Initials/Date :