History Form

Drs. Murray, Shin & Associates, 1556 Meridian Ave., San Jose, CA 95125

Date:_____

GENERAL INFORMATION:

Patient's Name:_____ Date of Birth:____/____/____ Age:_____Sex: M/ F
Address: _____
Home Phone No:_____Office Phone No:_____Cell Phone No:_____
e-mail:_____

Policy Holder:_____Date of Birth:_____Employer:_____
Home Phone No: _____Office Phone No: _____Cell Phone:_____
Address:_____
SS#_____ E-Mail Address:_____

Please fill out completely:

Self pay? Yes / No

	Medical Insurance	**Member ID No:**	**Group:**
Primary :	_____	_____	_____
Provider Phone number: _____			
Seconday:	_____	_____	_____
Provider Phone number: _____			

Medicare: Y/ N Medicare Supplementary: _____ID number: _____
Medicare Supplementary phone number: _____

Vision Insurance: _____ Member ID#: _____

This bill will be taken care of via: ___Cash ___Check ___ VISA ___ M/C

List Family Members Names and Ages:

_____ ____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Emergency Contact:_____Phone:_____

Whom can we thank for referring you to our office? _____

REASON FOR VISION EXAM: (Check those that are applicable)
**If learning or work related visual problem, then special additional History Form may need to be completed!*

___Periodic check-up
___Visual changes noted
___Visual symptoms
___Dr. Referral
___Sports related
___Contact Lens evaluation
___School referral
___*Learning problem
___*Job related visual problem (VDT/CRT)
___Broken/Lost glasses
___Need new frame or prescription sunglasses
___Other:_____

Last Full Visual Examination: ___1 yr ___2 yr ___>2 yr ___Never
Do you wear glasses? Yes/No Do you wear them for: ___Near ___Far ___Both
___Occupational use ___Recreational use
When were they prescribed?_____ First started wearing?_____

Do you wear Contact Lenses? Yes/No
If Yes, Type: ___Soft ___Gas Perm ___Daily Wear ___Extended Wear
How many years worn? _____ How old is your current pair?_____
If No, are you interested in Contact Lenses? Yes/No
Has your vision been changing over the past few years? Yes/No

Have you ever had:
___Serious eye injury/infection/surgery ___Injury to head/neck/back ___Vision Therapy/patching
Are you experiencing any of the following? (Check applicable items)
___Blur (___far ___near ___both)
___Eyestrain/fatigue
___Irritated/red/itchy eyes
___Loss of place with reading
___Light flashes/spots
___Sensitivity to light (sun/fluorescent light)
___Night vision/driving
___Glare problems
___Headaches

Any Family History of:
___Glaucoma ___Diabetes ___Cataracts ___High Blood Pressure
___Blindness ___Lazy Eye ___Nearsightedness (cannot see far away)

Present state of health: ___Excellent ___Good ___Fair ___Poor
Are you under a physician's care? Yes/No If yes, Dr.'s name:_____
If yes, for what?_____
Are you taking any medication? Yes/No If yes, what:_____
Do you have any allergies? Yes/No If yes, to what:_____
Do you smoke? Yes/No If yes, how much?____pk/day
Do you consume alcohol? Yes/No If yes, how much? ___Occasionally socially ___ Several times/month
___Every day ___>2 drinks/day
Describe any visual requirements of occupation:_____

Frequent sports/recreational activities/hobbies:_____

If you have questions about your vision on any of the following, please circle and we will be glad to answer them:

Contact Lenses (CL's) Prevention or Enhancement of Vision Safety Glasses
Photochromatic Lenses Sunglasses Laser Surgery Computer (stress) Lenses
Sports Eyewear Visual Training (Natural improvement of vision) Children's Vision
Learning Lenses Other:_____

COMPUTER USER QUESTIONS (COMPUTER USERS ONLY)

Approximately how many hours per day are you on a computer? ___1-2 ___ 2-4 ___ 4-6 ___ 6-8 ___ 8+

What type of computer? ___PC ___Laptop ___Both How large of a screen?_____

What is your approximate working distance? ___-13" ___13-18" ___18-24" ___24-36" ___+36"

Do you wear glasses when you are on a computer? ___Yes ___No
If yes, what type of design are they? ___Single vision ___General wear Rx
___Bifocal/ Occupational ___Progressive
___Specific for computer/near

Do you experience visual related symptoms such as: Rank 1-4: (1-mild/occasional < 4-significant/frequent
___Blur at distance after working ___Eyestrain ___Fatigue ___Headaches (frontal)
___Loss of place ___Sensitivity to light/glare ___Neck/shoulder aches
___Decreased comprehension (too many silly mistakes) ___Irritated dry/red eyes

What color screen do you work on most?_____
Are you sensitive to light and/or flicker? ___Yes ___No
If yes, how much? ___Slight ___Moderately ___Significantly

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of, my examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of LIGHTHOUSE OPTOMETRIC VISION PERFORMANCE CENTER when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. I authorize Dr. Bradford G. Murray and LIGHTHOUSE OPTOMETRIC VISION PERFORMANCE CENTER to exchange information with other professionals involved in my care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Patient's Signature Date:

I hereby give my permission to LIGHTHOUSE OPTOMETRIC VISION PERFORMANCE CENTER to

treat _____ .

(Patient's Name)

_____ _____

Patient's Signature Date:

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day/7 days a week. To avoid a cancellation fee, we request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

THANK YOU.

SINCERELY,

DR. BRADFORD G. MURRAY, O.D.
DR. JAMES S. SHIN, O.D.