Look! Optometry
Patient Information Form

451 Manhattan Beach Blvd. Suite D120
Manhattan Beach, Ca. 90266 Dr. Lester Silverman

Welcome to Look! Optometry **Today's Date**: ___________________

Last Name: ____________________ First Name: __________________ MI: ____ Gender: Male / Female

SSN (parent/guardian if minor): ________-______-________ Date of Birth: ______/______/______ Age: ______

Primary Address: _____________________________ City:_________________ State:_____ Zip:____________

Cell #:________________________ Home #:________________________ Work #:________________________

Other #: ___________________________ E-mail Address: ____

Employer: ______________________________ Occupation: ____

Name of Spouse (parent/guardian if minor):____

Emergency Contact: _____________________ Phone #: _____________________ Relationship: ______________

Are you a new patient? If yes, how where you referred to us? ____

Insurance Information **(Please Fill Out Completely If You Will Be Using Insurance)**

Name of **VISION** provider: _____________________ Name of **MEDICAL** insurance: ______________________

Name of **PRIMARY MEMBER**: ____ (full name, no nicknames)

SSN: __________-_______-___________ Date of Birth: ______/______/______ Employer: __________________

Member ID #: _________________________________ Relation to Patient: _________________________________

Personal Eye History

Reason for today's Visit? Routine___ Decreased Vision (dist/near) ___ All: ___ Other: ________________________

Have you had Lasik? _______ Please circle what you are interested in today: Contacts/Glasses/Sunglasses/Lasik

Date of last examination: _______________________ Name of Doctor: ____________________________________

Have you had eye surgeries/injuries (if yes please explain): ____

Do you wear glasses? Yes/No
Do you have back-up glasses? Yes/No
Are you hard on your glasses? Yes/No
Would you benefit from thinner, lighter lenses? Yes/No
Do you have problems with glare or reflections? Yes/No
Do you have sensitivity to bright lights? Yes/No
Do you spend a lot of time outdoors? Yes/No
Do you work on the computer for long periods? Yes/No If so how many hours? ______________________
Do you have computer vision problems? Yes/No
Do you have computer glasses? Yes/No
Do you wear contact lenses? Yes/No If yes, what type ___________________________
-Would you be interested in them? Yes/No

List the sports/hobbies you participate in:____

Please turn over form and complete the second page

Medical Information

Date of Last Medical Exam: ____________ Name of Medical Doctor: ________________________________

List any medications you take (including oral contraceptives, aspirin and over the counter meds): ______________

____

Do you have any allergies? If yes, explain: ____

Do you have any allergies to medication? If yes, explain: ________________________________

List all major injuries, surgeries and/or hospitalization you have had: __________________________

____ Are you nursing and/or pregnant? Yes / No

Review of Symptoms and Family History

Do you currently or have you ever had any problems in the following areas?

Gastrointestinal	Yes / No / Self / Relative	Diabetes	Yes / No / Self / Relative
Ears/Nose/ Throat	Yes / No / Self / Relative	Musculoskeletal	Yes / No / Self / Relative
Cardiovascular	Yes / No / Self / Relative	Integumentary (skin)	Yes / No / Self / Relative
Respiratory	Yes / No / Self / Relative	Mental	Yes / No / Self / Relative
Eyes	Yes / No / Self / Relative	Endocrine (glands)	Yes / No / Self / Relative
Neurological	Yes / No / Self / Relative	Blood / Lymph	Yes / No / Self / Relative
Genitourinary	Yes / No / Self / Relative	Allergies / Immunologic	Yes / No / Self / Relative
High Blood Pressure	Yes / No / Self / Relative	Other	Yes / No / Self / Relative

Please note any family history (parents, grandparents, siblings, children; living or deceased)
(If you mark yes, please specify which family member)

Blindness	Yes / No ______________	Diabetes	Yes / No ______________
Cataracts	Yes / No ______________	Heart Disease	Yes / No ______________
Crossed Eyes	Yes / No ______________	High Blood Pressure	Yes / No ______________
Macular Degeneration	Yes / No ______________	Kidney Disease	Yes / No ______________
Retinal Detachment	Yes / No ______________	Lupus	Yes / No ______________
Arthritis	Yes / No ______________	Thyroid Disease	Yes / No ______________
Cancer	Yes / No ______________	Other	Yes / No ______________

Social History

Do you use tobacco products? Yes / No Alcohol? Yes / No Other Substances Yes / No

Have you ever been exposed to or infected with: **HIV** Yes / No **Hepatitis** Yes / No **Gonorrhea** Yes / No

Syphilis Yes / No If yes, Please explain: ____

Do you have any other questions or concerns? ____

____

Staff Signature ___________________________ Date: ____________ Method Of Payment CASH, CHECK, CREDIT CARD, INS.

History Reviewed Date ____________ Pt. Initials ______ Staff initial ______ CASH, CHECK, CREDIT CARD, INS.

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