Welcome To Our Office

In order to provide us with a better understanding of your vision care needs, please complete the following history

Date/Fecha:____________ Date of birth/Fecha de nacimiento :_____/_____/________ Age/Edad:_______ Sex M / F

Name/Nombre:____ Date of last exam/Fecha de ultimo examen ocular:______________

Address/Direccion____

City/Ciudad:______________ State/Estado:_________ Zip/Codigo Postal:____________ Phone/Telefono:(   )_________________________

Social Security/Seguro Social:__________-__________-__________ Insurance/Aseguranza:____

Occupation/Ocupacion:_________________________ Email/Correo electronico:____

Reasons for today's visit/Razon de su visita (Check all that apply):

- ❑ **General Checkup/Chequeo General**
- ❑ **Blurred vision/ Vision borrosa**
- ❑ **Lost or broken glasses/Gafas perdidas o rotas**
- ❑ **Want new glasses/ Quiere lentes nuevos**
- ❑ **Contact Lense/Lentes de contacto:**
  - ❑ **Soft**
  - ❑ **Disposable**
  - ❑ **Bifocal**
  - ❑ **Colored**
- ❑ **Eyes feel tired/Ojos Cansados**
- ❑ **Spots or flashes/Ve manchas o destellos**
- ❑ **Double vision/Vision doble**
- ❑ **Light sensitivity/Sensibilidad a la luz**
- ❑ **Headaches/Dolor de cabeza**
- ❑ **Problems with present contacts/ Problemas con los lentes de contacto**
- ❑ **Eyes Water/Ojos llorosos**
- ❑ **Eyes itch/Comezon**
- ❑ **Pain in eyes/Dolor en los ojos**
- ❑ **Other/Otro:**
  ____
  ____
  ____
  ____

What activities do you participate/En que actividades participa?: ____

Sports/Deportes ____ Hobbies ____

Computers/Computadora (how many hours per day/ Cuantas horas al dia?): ____

About your general health/ Acerca de su salud general

- ❑ **High blood pressure/Alta presion**
- ❑ **Heart disease/Problemas de corazon**
- ❑ **Diabetes**
- ❑ **Glaucoma**
- ❑ **Allergies**
- ❑ **Cataracts/Cataratas**
- ❑ **Lazy Eyes/Ojos Perezosos**
- ❑ **Eye surgery/Cirujia en los ojos**
- ❑ **Retinal disorders/Desorden de retina**
- ❑ **Eye injuries/Lesiones oculares**
- ❑ **Cancer**
- ❑ **Other/Otro:____________________**
  ____
  ____

Are you allergic to any medicines/Alergico algun medicamento? ______ YES ______ NO If so please list: _______________________________

____

Has anyone in your family (blood relatives) had any above conditions? _______ YES _______ NO

(Alguien en su familia tenia alguno de las condiciones anteriores?)

If so, what relative? What condition? Please list here (Do not check in list above) ____

____

Are you Pregnant/Estas embarazada? _______ YES _______ NO

Please list any medications you are currently taking ____

Medicamentos que esta tomando ____

PLEASE TURN THIS SHEET OVER AND COMPLETE THE OTHER SIDE