

# Welcome to Natomas Eyeworks Optometry

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Mobile Phone (\_\_\_\_) \_\_\_\_\_  
 Email Address \_\_\_\_\_ Referred by \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Date of last eye exam \_\_\_\_\_ Were your pupils dilated? Yes / No

## Medical Information

How would you describe your general health? \_\_\_\_\_<sup>+</sup>  
 Do you smoke? Yes / No  
 Do you have any of these conditions or problems with any of these systems?  

High Blood Pressure	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
High Cholesterol	Yes / No	Respiratory	Yes / No	Muscles/bones/ Skin	Yes / No
Diabetes	Yes / No	Cardiovascular	Yes / No	Ears/Nose/Throat	Yes / No
Headaches	Yes / No	Urinary	Yes / No	Allergic/immunologic	Yes / No
Depression	Yes / No	Blood/lymph	Yes / No	Gastrointestinal	Yes / No

Other health conditions? \_\_\_\_\_  
 Allergies to medications? Yes / No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_  
 Current medications (Use reverse side of sheet, if needed) \_\_\_\_\_  
 Have you had any surgeries? Yes / No Type? \_\_\_\_\_ When? \_\_\_\_\_  
 Personal physician (*first and last name, if known*) \_\_\_\_\_ Date of last visit \_\_\_\_\_

## Family History

High blood pressure	Yes / No	Relation _____	Macular degeneration	Yes / No	Relation _____
Diabetes	Yes / No	Relation _____	Retinal detachment	Yes / No	Relation _____
Glaucoma	Yes / No	Relation _____	Cataracts	Yes / No	Relation _____

## Personal Eye Information

Do you have a history of any medical eye conditions? Yes / No If yes, what type? \_\_\_\_\_  
 Have you had any eye injury or surgery? Yes / No If yes, what type? \_\_\_\_\_ When? \_\_\_\_\_  
 Do you wear glasses? Yes / No Contact lenses? Yes / No Type (if known)? \_\_\_\_\_

## Primary Concern

What is the primary reason your visit today? \_\_\_\_\_

## Vision Correction

Are you interested in:  Laser Vision Correction?  Contact Lenses?  Glasses?

### Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ [Patient's Name], acknowledge that I have reviewed and under the Notice of Privacy Practices of Natomas Eyeworks Optometry.	
_____ Signature of Patient or Guardian	_____ Date