Fortuna Optometry
630 Ninth Street
Fortuna, CA 95540
(707) 725-5144

NAME:_____ Sex: M / F DOB_____SS#_____

Address:_____City_____State____Zip_____

Phone#_____Work#_____Cell#_____Email:_____

Employer:_____ Occupation:_____

Spouse or Legal Guardian:_____ Last Eye Exam _____

Last Medical Exam_____Name of Medical Doctor _____Phone#_____

Vision Insurance:_____Medical Insurance:_____ID#_____

FAMILY HEALTH HISTORY

Please indicate immediate family members with: M=Mother F=Father B=Brother S=Sister

☐Blindness	☐Glaucoma	☐Heart Disease	☐Thyroid Disease
☐Cataract	☐Macular Degeneration	☐High Blood Pressure	☐None
☐Crossed Eyes	☐Retinal Detachment	☐Lupus	☐Other:_____
☐Diabetes	☐Cancer	☐Arthritis	_____

PATIENT'S OCULAR/ MEDICAL HISTORY

Do you have any allergies to medications? ____Yes ____No. If yes, please list_____

List all the **medications** you are currently taking:_____

_____Pharmacy:_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

Are you pregnant and/or nursing? ____ Yes ____No Are you sensitive to light? ____ Yes ____No

Do you wear glasses? ____ Yes ____No If yes, How old is your current pair of glasses? _____

Do you wear contact lenses? ____ Yes ____No Type of contact lenses:_____

Are you interested in contact lenses? ____ Yes ____No

Please check any conditions that you have or have had in the past:

☐Blurred Vision	☐Macular Degeneration	☐**Diabetes**	☐Thyroid
☐Loss of Vision	☐Glaucoma	☐High Blood Pressure	☐ Cancer
☐Double Vision	☐Pain	☐High Cholesterol	☐ Arthritis
☐Redness	☐Headaches	☐ Dizziness	☐ Anemia
☐Crossed Eyes	☐Excessive Tearing	☐Stroke	☐ Anxiety/Depression
☐Lazy Eye	☐Dryness	☐ Seizure	☐ Sinus Congestion
☐Eye Surgery	☐Itching/Burning	☐Migraine	☐ Emphysema
☐Cataract	☐Mucus Discharge	☐Spots	☐ Sleep Apnea
☐Retinal Detachment	☐Eye Injuries	☐Night Blindness	☐ None
☐Flashes/Floaters	☐Eye Infection/Redness	☐Asthma	☐ Other_____

_____

SOCIAL HISTORY

Do you use tobacco products? ____YES ____NO (If yes) type/ amount/ how long:_____

Do you drink alcohol? ____YES ____NO (If yes) type/ amount/ how long:_____

Do you use recreational drugs? ____YES ____NO (If yes) type/ amount/ how long:_____

Have you ever been exposed to or infected with: _____ Gonorrhea _____Hepatitis _____HIV _____Syphilis

Referred by? _____

Hobbies_____

NOTICE OF PRIVACY

Acknowledgement of Receipt of Privacy Notice(HIPPA)

By signing below, I acknowledge that I have read/receive the copy of the Notice of Privacy Practices for review.

_____ _____

(Patient's Signature or Legal Representative) (Date)

_____ _____

(O.D Signature) (Date)