Burbank Family Optometry
1112 W. Burbank Blvd #204 Burbank, CA 91506
(818) 846-9075

Last Name___________________**First Name**_______________**MI**____**Today's Date**:____________
Address_________________________________**Martial Status:** Single Married Divorced Widowed
City___________________**Zip Code**_________**State**_____**Age**:____ **Date of Birth**____/___/_______
Telephone(CELL)_____________(**Other: Home/Work**)___________**Social Security** # ___/___/____
Date of last exam:___/___/___ **Last Physical**:__/___/___ **Name of Medical Doctor**:________________
Occupation:_________________ **Hobbies**:_________________ **Computer Use Hours**:____________
Email:________________________@_______________ **May we text you?** Yes/No

<u>Vision Complaints:</u> Blurred Distance/ Intermediate/ Near Headaches Redness Pain
Itching Burning
Floaters Dry eye None Other: PLEASE EXPLAIN:_____________________________________
Do you wear glasses? Yes/No If yes, how old is current pair?_____________________________
Do you wear contacts? Yes/No If yes, how old is present pair?_____________________________
Are you interested in: New Glasses Sunglasses Contacts Other:_______________________
Type of Contacts you wear? Soft Dailies 2Weeks Monthly Rigid Extended Wear
Other:______________ **Are they comfortable?** Yes/No Please Specify:__________________________

<u>Are you allergic to any Ocular/ Systemic medications?</u> Yes/No Please specify:___________
____

<u>Medical History:</u> *Please list all medications you are currently taking(including over the counter, vitamins and herbal therapy):*____
____
List all major surgeries(eye surgery included):____
____

<u>Please circle if any of the conditions to you or family member (blood relative only)</u>

- Glaucoma YES NO WHO_____________________________________
- Macular Degeneration YES NO WHO_____________________________________
- Retinal Detachment YES NO WHO_____________________________________
- Cataracts YES NO WHO_____________________________________
- Corneal Problem YES NO WHO_____________________________________
- Eye Turn YES NO WHO_____________________________________
- High Cholesterol YES NO WHO_____________________________________
- Diabetes YES NO WHO_____________________________________
- High Blood Pressure YES NO WHO____________________________________
- Cancer YES NO WHO_____________________________________
- Heart Disease YES NO WHO_____________________________________

Do you smoke? Yes/No Packs Per Day___________ Years Smoking__________________
Do you drink? Yes/No Social Use Only 1-2 Drinks Daily Above Average Use
Are you pregnant? Yes/No Are you nursing? Yes/No

REVIEW OF SYSTEMS: *Please indicate below if you have or ever had problems with the following conditions*

Allergic/Immunologic
__None
__Lupus (SLE)
__Seasonal Allergies
__Environmental Allergies
__Other: (i.e. Latex)

Cardiovascular
__None
__High Blood pressure
__Heart Disease
__Vascular Disease
__High Cholesterol
__Other:________

General Health
__None
__Weight Gain/Loss
__Fever
__Trauma
__Fatigue
__Other:___________

Endocrine/Glands
__None
__Diabetes (I or II)
__Hormone Dysfuction
__Thyroid Dysfuction
__Other:__________

Gastrointestinal
__None
__Crohn's Disease
__Colitis
__Acid Reflux/ Ulcer
__Other:__________

Genital/Urinary
__None
__Urinary Tract Infection
__HIV Positive
__Herpes/Chlamadia
__Other:____________

Ear/Nose and Throat/Head
__None
__Sinusitis
__Upper Respiratory
Tract Infection
__Headaches
__Other:______________

Hematologic/Lymphatic
__None
__Anemia
__Leukemia
__Bleeding Disorder
__Other:_____________

Skin/Intergumentary
__None
__Eczema
__Rosacea
__Psoriasis
__Other:____________

Muscle/Skeletal
__None
__Arthritis
__Rheumatoid Arthritis
__Fibromyalgia
__Ankylosing Spondylitis
__Other:_____________

Neurological
__None
__Multiple Sclerosis
__Epilepsy
__Tremors
__Other:_______________

Psychiatric
__None
__Depression
__Bi-Polar
__Schizophrenia
__Anxiety
__Other:_____________

Respiratory
__None
__Asthma
__COPD
__Emphysema
__Other:_____________

VERY IMPORTANT (NEW PATIENTS ONLY) Who may we thank for referring you to our office?
Internet:___________________ Friend:______________________ Other:__________________________

Lifestyle Question:

- Do you think you might benefit from thinner, lighter lenses? **Yes/No**
- Do you spend time outdoors? **Yes/No** How much?_____________
- Do you prefer not to wear your glasses at times? **Yes/No**
- Do you have more than one pair of current prescription eyewear? **Yes/No**
- Do you have family members in need of eye care? **Yes/No**
- Do you have interest in a non-surgical approach to vision correction? **Yes/No**

Preferred Language (Circle One) English Spanish Armenian Other:_________________
Race: (Circle One) African American Caucasian Hispanic Native American Hawaiian Asian Armenian
Ethnicity: (Circle One) Hispanic/Latin Not Hispanic Native American/Other:_______________
Communication Preferred: (Circle One) Phone Email Text

Please sign below to acknowledge that this form is current
Signature:________________________________Date:__________________Reviewd by Doctor's Initials__
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