New Patient Information

Dr. Chester Quan, OD
Dr. Christina Chang, OD
Dr. June Huang, OD

□ Mr □ Mrs □ Ms □ Miss □ Dr Sex: □ M □ F

Last Name: _____ First Name: _____ M. Initial :_____
Birth date :_____Age:____ Race/Ethnicity(Optional):_____PrimaryLanguage:_____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Cell Phone: _____ Work # :_____
Email Address: _____

Vision Insurance : _____ Primary Member's Name: _____
Primary's last 4 of SSN, Date of birth or SSN: _____

Patient History

Primary reason for today's visit: (check all that applies)
□ Annual Eye Exam □ Contact Lens Exam □ Vision or Eye Health Problem □ Other
Last Complete Eye Exam:_____ Have you ever had your eyes dilated? _____ When?_____

Is there a **family history** of : (Please check all that applies)
□ Diabetes □ High Blood Pressure □ High Cholesterol □ Glaucoma □ Cataract □ Macular Degeneration
Relationship_____

Do **you** have: □ Diabetes □ High Blood Pressure □ High Cholesterol □ Glaucoma □ Cataract
□ Macular Degeneration
Are you being treated for any other medical conditions? _____
Are you currently taking any medications? _____
Are you allergic to any medications? _____
Do you consider yourself a : □ Non-Smoker □ Current Smoker □ Former Smoker

Have you ever had any eye infection, disease, injury or surgery? _____
Do you have headaches which you think are related to your eyes? _____
Do you experience : □ Dry Eyes □ Light Sensitivity □ Poor night vision □ Glare issues

What sports and/or hobbies do you enjoy? _____

Are you currently wearing contact lenses? If so, which brand? _____
Are you interested in wearing contact lenses? □ Yes □ No
Do you sleep with your contacts? □ Yes □ No
Which lens care system do you use? □ Revitalens □ Optifree □ Clear Care □ Boston □ Other _____

Have you had Lasik? □ Yes □ No Are you interested in Lasik? □ Yes □ No

****

I have read and understand the privacy policies of Eyedare Optometric.

Print Patient's Name: _____ Date:_____

Patient's Signature (Parent or Guardian if under 18yrs old)_____

Print Name of Parent/Guardian: _____ Relationship to Patient_____