HORIZON OPTOMETRIC GROUP

9600 Bolsa Avenue, Suites C & H
Westminster, CA 92683

Phuong T. Le, O.D.
Kellee Leangsok Tea, O.D.

PATIENT HISTORY

Please take a moment to complete the following information. Thank you.

Name ______________________________________ **Age:** _____ **Birth Date:** _____/_____/_____ ☐**Male** ☐**Female**

Ethnicity: ☐Vietnamese ☐Chinese ☐Caucasian ☐Japanese ☐Hispanic ☐African American ☐Filipino ☐Other ________________

YOUR MEDICAL HISTORY

Reviewed by: _______

Date of Last Physical: ______ /______ /_______ **Primary Physician's Name**: ______________________________________

High Cholesterol? ☐Yes ☐No
Diabetes? ☐Yes ☐No
High Blood Pressure? ☐Yes ☐No
Heart Condition? ☐Yes ☐No

Asthma? ☐Yes ☐No
Seasonal Allergies? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No
Do you use eye drops? ☐Yes ☐No

Other health conditions not listed:
____
If yes, which?________________

Please check any medication/drugs you are taking:

☐High Cholesterol ☐Diabetes ☐High Blood Pressure ☐Heart Condition ☐Other ______________________________________

Are you allergic to any medication or drugs? ☐Yes ☐No If yes, which? ______________________________________

Do you smoke? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐No Do you take non-prescription drugs? ☐Yes ☐No

☐ Please check this box if there have been no changes to your medical and ocular history since your last visit

YOUR EYE HISTORY

Date of your last eye exam: _____/_____/_____ What is your previous eye doctor's name**?** ______________________________

Do you wear glasses? ☐Yes ☐No Contact lenses? ☐Yes ☐No If yes, which type? ☐Soft ☐ Hard Brand: ______________________

Cataracts? ☐Yes ☐No Glaucoma? ☐Yes ☐No Lazy eye? ☐Yes ☐No Loss of Vision? ☐Yes ☐No

Eye Surgery or Injury? ☐Yes ☐No If yes, please explain: ____

Family History

(Check all that apply to *anyone* in your *immediate family*)

☐ Allergies
☐ Asthma
☐ Blackouts
☐ Blindness
☐ Cancer
☐ Cataracts
☐ Diabetes
☐ Drug sensitivity
☐ Eye Turn
☐ Glaucoma
☐ Hay Fever
☐ Heart Condition
☐ High blood pressure
☐ Lazy eye (Amblyopia)
☐ Migraine headaches
☐ Poor color vision
☐ Skin conditions
☐ Thyroid condition
☐ Tuberculosis

Patient's Health History

(Check all that apply to *you*)

☐ Fever
☐ Weight loss
☐ Eating disorders
☐ Sleeping disorders
☐ Depression
☐ Hearing loss
☐ Sinus congestion
☐ Runny nose
☐ Chronic cough
☐ Dry throat/mouth
☐ Palpitation
☐ Frequent dizziness/Headaches
☐ Shortness of breath
☐ Rashes
☐ Dry Skin
☐ Thyroid condition
☐ Hot/cold intolerance
☐ Anemia
☐ Lymph node swelling
☐ Migraines
☐ Seasonal allergies

Patient's Eye Symptoms

(Check all that apply to *you*)

☐ Blurred distance vision
☐ Blurred near vision
☐ Burning eyes
☐ Discomfort at NEAR tasks
(e.g. reading, sewing, etc.)
☐ Double vision
☐ Dry eyes
☐ Eye strain
☐ Eye pain
☐ Fluctuation in vision
☐ Headaches around eyes
☐ Itchy eyes
☐ Light sensitivity
☐ Loss of side vision
☐ Mucous discharge
☐ Red eyes
☐ See flashing lights
☐ See floating spots
☐ Temporary loss of vision
☐ Twitching eyelids
☐ Watering eyes

____

Patient's Signature (Guardian's Signature if under 18)

_______/______/_______
Date