Valdez Optometry

Dr. Lynn Valdez O.D. and Dr. Tammy Nguyen O.D.

231 Montgomery Street, San Francisco, CA 94104

Today's Date ________ / ________ / ________

First Name ______________________________ MI ______ Last Name ______________________________

Preferred Name______________________________ **Gender:** Male ☐ Female ☐ Neutral ☐ Rather Not Say ☐

VSP - Please provide us with the last four of your SOCIAL SECURITY or Member's unique ID number: ____________________

Address ______________________ Apt. ________ City ______________________ Zip ____________

Cell Phone ______________________ Work Phone ______________________ Referred By ______________

E-Mail ______________________________ How do you prefer to be contacted? E-Mail ☐ Phone ☐

Date of Birth ________ / ________ / ____________ Occupation ______________________ Employer ______________

Emergency Contact: Name ______________________ Relationship ______________ Phone ______________

Are you obtaining, renewing, or updating your Contact Lens prescription Rx for this year? **YES** ☐ **NO** ☐

____________ ***Patient's Initials*** *I understand that my Contact Lens prescription Rx will expire after ONE YEAR (12 months). Contact Lens prescription Rx needs to be updated yearly.* ***Please Note:*** *Contact Lens Services are* ***NOT*** *incuded in the annual exam fees. The Contact Lens Exam is a seperate exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. Additional time and fees will be required.*

Medical Information:

Do you have problems with any of these systems? Please check one: **YES** or **NO**

Cardiovascular Yes ☐ No ☐ Nervous Yes ☐ No ☐ Skin Yes ☐ No ☐

Gastrointestinal Yes ☐ No ☐ Endocrine Yes ☐ No ☐ Urinary Yes ☐ No ☐

Ears/Nose/Throat Yes ☐ No ☐ Blood/Lymph Yes ☐ No ☐ Headaches Yes ☐ No ☐

Elevated Cholestreol Yes ☐ No ☐ Muscles/Bones Yes ☐ No ☐ Respiratory Yes ☐ No ☐

High Blood Pressure Yes ☐ No ☐ Allergic/Immunologic Yes ☐ No ☐

Diabetes Yes ☐ No ☐ Type ______________________ Date of diagnosis? ________ / ________ / ________

Do you smoke? Yes ☐ No ☐ How many years? ________ Quit? Yes ☐ No ☐ When? ________ / ________ / ________

Allergic to Medication Yes ☐ No ☐ Type ______________________ Reaction ______________________

List any medication currently taking: ____

Have you had any surgeries? Yes ☐ No ☐ What kind? ______________________ When? ________ / ________ / ________

Name of your primary care physician ______________________________ Last date of visit ________ / ________ / ________

Family History:

Diabetes Yes ☐ No ☐ Who? ______________ Retinal Detachment Yes ☐ No ☐ Who? ______________

Cataracts Yes ☐ No ☐ Who? ______________ High Blood Pressure Yes ☐ No ☐ Who? ______________

Glaucoma Yes ☐ No ☐ Who? ______________ Macular Degeneration Yes ☐ No ☐ Who? ______________

Personal Eye Information:

Have you had any eye operations? Yes ☐ No ☐ Type ______________________ When? ________ / ________ / ________

Do you have or had the following? Glaucoma Yes ☐ No ☐ Cataracts Yes ☐ No ☐

Macular Degeneration Yes ☐ No ☐ Retinal Detachment Yes ☐ No ☐ Dry Eyes Yes ☐ No ☐

Do you wear glasses? Yes ☐ No ☐ Do you wear contact lenses? Yes ☐ No ☐ Brand ______________________

Are you interested in Lasik? Yes ☐ No ☐ Maybe ☐ Additional Information: ______________________________

I have received and read the HIPAA privacy policy at Valdez Optometry - Please SIGN:______________________________

Reviewed by ______________________ NO changes - Date ________ / ________ / ________

Doctor's Use Only Reviewed by ______________________ NO changes - Date ________ / ________ / ________

Reviewed by ______________________ NO changes - Date ________ / ________ / ________