Valdez Optometry

Lynn Valdez O.D.

231 Montgomery Street
San Francisco, CA 94104

Today's Date ________

First Name ________________________ MI ___ Last Name ________________________

Perfered Name ____________________ Gender: M. ☐ F. ☐ Neutral ☐ Rather Not Say ☐

Address ______________________________ Apt. _____ City _________________________, CA Zip _______

Cell Phone _______________ Work Phone ________________ Referred By ___________________

E-mail ____ How do you prefer to be contacted? _______________

Date of Birth ________ Occupation ___________________________ Employer _________________________

Emergency Contact: Name ________________________ Relationship __________ Phone _______________

Are you obtaining, renewing, or updating your Contact Lens prescription for this year? ***Yes*** ☐ ***No*** ☐
I understand that my Contact Lens prescription will expire. ***Please Note****: Contact Lens Services are NOT included in the annual exam fees. The Contact Lens exam is a separate 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 ☐	Respiratory	Yes ☐	No ☐
Elevated Cholesterol	Yes ☐	No ☐	Muscles/Bones	Yes ☐	No ☐	Headaches	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 ☐ Kind? ______________________________ When? ________

Name of Your Primary Care Physician __________________________________ Last Date of Visit ________

Family History:

Diabetes	Yes ☐	No ☐	Who? ________	Macular Degeneration	Yes ☐	No ☐	Who? ________
Cataracts	Yes ☐	No ☐	Who? ________	Retinal Detachment	Yes ☐	No ☐	Who? ________
Glaucoma	Yes ☐	No ☐	Who? ________	High Blood Pressure	Yes ☐	No ☐	Who? ________

Personal Eye Information:

Have you had any eye operations? Yes ☐ No ☐ Type? ____________________________ Date ________

Do you have or ever 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 ☐ Contact Lenses? Yes ☐ No ☐ Type/Brand ________________

Additional information: ____ Interested in Lasik: Yes ☐ No ☐

I have received and read the HIPAA Privacy Statement SIGN: ____

Doctor Use Only

Reviewed by ____________________________________ No changes Date __________

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Reviewed by ____________________________________ No changes Date __________