Dr. Hernandez Optometry
Medical History and Lifestyle Questionnaire

Today's Date: _____
Patient Name: _____**DOB:** _____**Occupation:** _____
We are now making greater use of email to communicate with our patients. To help us provide the most prompt service possible, please enter your current **E-MAIL** address below:

NOTE: All patient information is kept strictly confidential. Your address is never shared.
If we have something important to tell you or we can't contact you otherwise, would like a text message sent to your cellular phone? No:☐ Yes:☐: (_____)_____-_____
Primary Care Physician:_____
Phone Number: (_____)_____-_____
Please select any of the following insurance plans that you are currently enrolled in:

☐Blue Shield	☐Blue Cross	☐Care 1st	☐Medi-care	☐Medi-Cal
☐AltaMed	☐Healthnet	☐LA Care	☐Allied Pacific	☐Proyecto Del Barrio
☐Aetna	☐Kaiser	☐CIGNA	☐United Health Care	

Are you in good health?
☐No ☐Yes
Do you have any of the following health conditions? *(Check all that apply)* ***AND YEAR DIAGNOSED***

☐None	☐Heart Disease_____	☐High Blood Pressure_____
☐Stroke_____	☐Diabetes_____	☐GERD_____
☐HIV/AIDS_____	☐High Cholesterol_____	☐Cancer_____
☐Radiation Treatment____	☐Depression_____	☐Thyroid Disorder_____
☐Asthma _____	☐Arthritis _____	☐Anxiety_____
☐Headaches_____	☐Allergies (please specify)_____	

☐Other (please specify) _____
☐Surgeries (please specify) _____
Ocular History:

☐Dry Eyes_____	☐Ophthalmic Migraine_____	☐Strabismus_____
☐Vitreous Floaters_____	☐Glaucoma_____	☐Cataracts_____
☐Macular Degeneration_____		
☐Diabetic Retinopathy_____		

Do you take any medications?
☐No ☐Yes. If yes, please list names and dosages:_____
_____
Do you have any allergic reactions to medications or other substances?
☐No ☐Yes. If yes, please list_____
Please check Yes or No to the following questions:
Do you smoke?
☐No ☐Yes. If yes, how much? _____
Do you drink alcohol?
☐No ☐Yes. If yes, how many drinks do you have weekly? _____
Do you use other substances?
☐No ☐Yes

CONTINUED →

Do you have a family history of any of the following? (*check all that apply)* ***and*** ***SPECIFY FAMILY MEMBER***

- ☐Diabetes_____
- ☐Heart Disease_____
- ☐High Blood Pressure_____
- ☐High Cholesterol_____
- ☐Asthma_____
- ☐Cataracts_____
- ☐Retinal Detachment_____
- ☐Diabetic Retinopathy_____
- ☐Glaucoma_____
- ☐Macular Degeneration_____
- ☐Other_____

Do you have any of the following? If yes, please check box.

- ☐Dry Eyes
- ☐Blurred Vision: ☐Distance ☐Intermediate (computer) ☐Near (reading)
- ☐Eye Injuries_____
- ☐Eye Surgeries_____

Are you interested in any laser vision correction?

- ☐No ☐Yes

What do you like about your current glasses or contacts (color, style, fit, etc)?

_____

_____

Are you interested in any of the following:

☐Contact Lenses
☐Transition Lenses
☐Glare Reducing Coating
☐Lighter, Thinner Lenses
☐Sunwear
☐Sports Goggles

FOR DOCTOR USE ONLY

Lens Options Discussed:

☐Bifocal
☐Progressive
☐Transitions
☐Anti-Reflective Coating
☐Other:_____

SEND REPORT? ☐YES ☐NO

Examining Dr: _____
Optician: _____
Exam Technician: _____

Notes: _____
_____

OMNR:_____