

SHASTA VISION GROUP, INC.

Dr. Duane T. Brooks
Optometrist



Dr. Annelle G. Maygren
Optometrist

110 Chestnut Street, Mt. Shasta, CA 96067 530-926-2033

Welcome to our office. By completing this history form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please ask.

GENERAL INFORMATION

Date: _____

Method of Payment: Check / Cash / Credit Card _____ Insurance _____ Medi-Cal _____

Mr _____ Mrs _____ Ms _____ Name _____ Date of Birth _____

Sex M _____ or F _____ Social security # _____ / _____ / _____ Age _____

Address _____ City _____ State _____ ZIP _____

PO Box _____ Home Phone _____ Work Phone _____

Employer _____ Occupation _____

E-mail: _____ Spouse/Parent/Guardian (If apply) _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear of our Office _____

MEDICAL HISTORY

Last Eye Exam _____

Do you wear Glasses? NO / YES If YES, How old are your lenses? _____

Do you wear Contact Lenses? NO / YES If YES, How old is your present pair? _____

Optometrist _____,

Medical Doctor _____ Last Medical Exam _____

Do you have any allergies to Medications? NO / YES If YES, Explain: _____

List any medications you take (including oral contraceptives, Aspirin, over the counter medications, vitamins, herbs, and home remedies): _____

Have you had **Refractive Surgery** (Lasik, RK, etc.)? NO / YES Date: _____ Doctor: _____

Are you currently pregnant or nursing? NO / YES

Have you had Cataract Surgery? NO / YES Right Eye Date _____ Left Eye Date _____ Doctor? _____

Please note any *Family History* (Parents, Grandparents, Siblings) for the following conditions:

	No	Yes	Relationship	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	_____		
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____				
	No	Yes	Relationship				

Do you drive? NO / YES If YES, Do you have visual difficulties when driving? NO / YES

If YES, please describe: _____

Do you use Tobacco products? NO / YES If YES, Type / Amount / How Long: _____

Do you drink alcohol? NO / YES If YES, Type / Amount / How Long: _____

Do you use illegal Drugs? NO / YES If YES, Type / Amount / How Long: _____

Have you ever been exposed to or infected with: _____Gonorrhea _____Hepatitis_HIV _____Syphilis

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO

What are your current visual needs that you would like to have addressed today? _____

Do you currently or have you ever had any problems in the following areas?

No Yes ?

Explain / List Medications

Constitutional (fever, wt gain / loss) _____

Integumentary (skin) _____

NEUROLOGICAL

Headaches _____

Migraines _____

Seizures _____

EYES

Amblyopia (lazy eye) _____

Strabismus (wandering eye) _____

Blurred Vision _____

Distorted Vision / Halos _____

Loss of Side Vision _____

Double Vision _____

Dryness _____

Foreign Body Removal _____

Mucous Discharge _____

Redness _____

Sandy or Gritty Feeling _____

Itching _____

Burning _____

Foreign Body Sensation _____

Excess Tearing / Watering _____

Glare / Light Sensitivity _____

Eye Pain or Soreness _____

Chronic Infection of eye or lid _____

Sties or Chalazion _____

Flashes of light _____

Floaters in vision _____

Tired Eyes _____

EARS, NOSE, MOUTH, THROAT

Allergies / Hayfever _____

Sinus Congestion _____

Runny Nose _____

Post-Nasal Drip _____

Chronic Cough _____

Dry Throat / Mouth _____

VASCULAR

Diabetes _____

Heart Pain _____

High Blood Pressure _____

Vascular Disease _____

GASTROINTESTINAL

Diarrhea _____

Constipation _____

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis _____

Muscle Pain _____

Joint Pain _____

LYMPHATIC / HEMATOLOGIC

Anemia _____

Bleeding Problems _____

Allergic / Immunologic _____

Thyroid / other glands _____

Kidney / Genitals / Bladder _____

Psychiatric (anxiety, depression) _____

DATE _____ / _____ / _____ **Doctor's Initials** _____