

Dr. Connie S. CHIANG & Dr. Walter J. CHAO

WELCOME TO OUR OFFICE

Date \_\_\_\_\_

We are happy to have you as our patient. Please fill out the following information so that we may better serve you.

Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ H Phone \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 E-mail \_\_\_\_\_ Employer \_\_\_\_\_ Position \_\_\_\_\_ W Phone (\_\_\_\_) \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Whom may we thank for referring you to this office? \_\_\_\_\_  
 Other family members still living at home:  
 Spouse \_\_\_\_\_ Age \_\_\_\_\_ Last Eye Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_ Name of Eye Doctor \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_ Last Medical Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_ Name of Medical Doctor \_\_\_\_\_

**Ocular History:**

- List any of the following that you have had: crossed eyes, lazy eyes, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury \_\_\_\_\_
- List any problems you are currently having with your eyes \_\_\_\_\_
- Are you pregnant and/or nursing?  No  Yes
- Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_
- Do you wear contact lenses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_
- Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable  Yes  No
- Do you work with a computer?  No  Yes
- List any sports or hobbies you enjoy \_\_\_\_\_
- Have you ever thought about Laser Vision Correction?  No  Yes

**Medical History:**

- Do you have any allergies to medications?  No  Yes If yes, please explain \_\_\_\_\_
- List any medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies): \_\_\_\_\_
- List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

**Family History:**

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	No	Yes	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**\*\*Please turn this form over to complete side two\*\***

**Social History:**

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive?  No  Yes If yes, do you have visual difficulty 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

**Review of Systems:**

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

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
<b>CONSTITUTIONAL</b>				<b>EARS, NOSES, MOUTH, THROAT</b>			
-Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>				-Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>				<b>RESPIRATORY</b>			
-Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VASCULAR / CARDIOVASCULAR</b>			
-Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Sandy or gritty Felling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			
-Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Diarrhea / Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASROURINARY</b>			
-Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Genitals / Kidney / /Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES / JOINTS / MUSCLES</b>			
-Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LYMPHATIC / HEMATOLOGICAL</b>			
-Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>				<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have any conditions not listed, please explain and list medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

I understand I am financially responsible for the services rendered. Please check the method of payment for today's professional services: ~~CASH~~ ~~Check~~ MasterCard VISA

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**\*\*Thank you for your time\*\***