Family Eyecare Center of Optometry
Dr. Harold T. Ashcraft, O.D.
8735 La Tijera Blvd., Los Angeles, CA 90045
310-670-4655 or 310-670-4411
Website: www.drashcraft.com, Email: drsashcraft@gmail.com

Patient Information Form

Title: Dr. / Mr. / Mrs. / Ms.
Full Name _____
Street _____
City _____ State _____ Zip _____
Home Phone (___)_____
Cell Phone (___)_____
Work Phone (___)_____
E-mail _____

Today's Date _____
Status: Married / Divorced / Single / Widow(er) / Domestic Partner
Date of Birth _____ Age: _____ Sex: M F
Driver's License number _____
Social Security number _____
Occupation (Grade) _____
Employer (School) _____
I was referred by: _____

Name of Family Members at Home	Relationship	Age	Patient of Ours?
			Y N
			Y N
			Y N

Vision Insurance: _____

ID Number: _____ Group Number: _____

Subscriber Name:_____ Subscriber SSN: _____ Subscriber Date of Birth: _____

Medical Insurance: _____ PPO HMO Medicare Other

ID Number: _____ Group Number: _____

Subscriber Name:_____ Subscriber SSN: _____ Subscriber Date of Birth: _____

What is the main reason for your visit today?

Which of the following symptoms do you experience?

❑ Blur-Distance	❑ Flashes	❑ Burning	❑ Glare-Indoor
❑ Blur-Near	❑ Floaters	❑ Dryness	❑ Glare-Outdoor
❑ Blur-Computer	❑ Spots	❑ Grittiness	❑ Night Blindness
❑ Eyestrain	❑ Haloes	❑ Itching	❑ Light Sensitivity
❑ Fatigue	❑ Double Vision	❑ Redness	❑ Decreased CL Wear
❑ Pain	❑ Twitching	❑ Stinging	❑ Dizziness
❑ Headaches	❑ Growths	❑ Tearing	❑ _____

Financial Policy: Payment for professional services is expected in full when services are rendered. Eyewear or contact lenses require a 50% deposit, with the balance due at dispensing. Spectacle lenses are special order materials and cannot be returned for credit. Unopened unmarked soft contacts can be returned for credit or exchange within 30 days. Contact lens professional services are not refundable. Returned checks are subject to a $25 fee. Bills over 30 days old may be assessed a $5 late/billing fee. Should this account be sent to collection, reasonable costs, expenses and attorney's fees may be assessed.

I acknowledge that I have received a copy of the *Notices of Privacy Practices*, available from our receptionist. You can also review this on our website: www.drsashcraft.com.

Patient name: _____ Date: _____

Signature of patient (or parent/guardian for minors): _____

❑

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Patient Medical Form

Name: _____ Date: _____ Birthdate: _____

Personal Medical History

Medical Condition	Medication
Vascular	
❑ Diabetes	_____
❑ Blood Pressure	_____
❑ Heart/Vascular	_____
Endocrine	
❑ Thyroid	_____
Psychiatric	
❑ Anxiety/Depression	_____
❑ Anti-Histamine	_____
❑ Eye Drops	_____
❑ Cholesterol	_____
❑ Oral Contraceptives	_____
❑ Other	_____
❑ None	

Family Medical History

Medical Condition	Family Member (i.e. mother)
❑ Cataracts	_____
❑ Glaucoma	_____
❑ Lazy Eye	_____
❑ Macular Degeneration	_____
❑ Retinal Detachment	_____
❑ Allergies	_____
❑ Arthritis	_____
❑ Blood Pressure	_____
❑ Diabetes	_____
❑ Heart Disease	_____
❑ Thyroid	_____
❑ Other	_____
❑ Other	_____

List all allergies or allergies to medications:

Constitutional

- ❑ Good General Health
- ❑ Recent Weight Gain/Loss
- ❑ Change in Appetite
- ❑ Fatigue

Social History

Do you drive? **Y / N**
Do you smoke? **Y / N**
Do you drink? **Y / N**

Review of Systems

Please select Yes(Y) or No(N)

Cardiovascular

Y	N	
❑	❑	Cardiovascular Disease
❑	❑	High Cholesterol
❑	❑	High Blood Pressure

Endocrine

Y	N	
❑	❑	High Cholesterol
❑	❑	Diabetes Mellitus
❑	❑	Thyroid Disorder

Gastrointestinal

Y	N	
❑	❑	Diarrhea
❑	❑	Intestinal Obstruction
❑	❑	Constipation
❑	❑	Ulcer

Genitourinary

Y	N	
❑	❑	Bladder Infections
❑	❑	Menopause
❑	❑	Prostate Disorder

Ears, Nose, Mouth, Throat

Y	N	
❑	❑	Dizziness
❑	❑	Dry Mouth
❑	❑	Headaches
❑	❑	Hearing Loss
❑	❑	Migraines

Hematological/Lymphatic

Y	N	
❑	❑	Anemia
❑	❑	Breast Carcinoma
❑	❑	Bleeding Easily

Immunologic

Y	N	
❑	❑	No Reported Symptoms
❑	❑	Bacterial Infection
❑	❑	Herpes

Integumentary (Skin)

Y	N	
❑	❑	Acne Rosacea
❑	❑	Atopic Dermatitis
❑	❑	Dry Skin

Musculoskeletal

Y	N	
❑	❑	Arthritis
❑	❑	Osteoporosis

Neurological

Y	N	
❑	❑	Headache
❑	❑	Migraine
❑	❑	Seizures
❑	❑	Vertigo

Psychiatric

Y	N	
❑	❑	Attention Disorder (ADD)
❑	❑	Anxiety
❑	❑	Depression
❑	❑	Insomnia

Respiratory

Y	N	
❑	❑	Asthma
❑	❑	Bronchitis
❑	❑	Emphysema
❑	❑	Smoker

Mood and Affect: app other

Oriented to time, place and person: Y / N

Vision Consultation Questionnaire

Please answer the following: (If yes, please check the boxes that apply.)

- ❑ Are you planning to get new eyewear today?
- ❑ Are you interested in contact lenses?
- ❑ Are you interested in laser vision correction?

Computer Usage: Hours/Day ____
How long can you use the computer before experiencing eyestrain? Minutes ___ Hours ___ Never___

How much time do you spend outdoors in the sun each week? Hours _____

- ❑ Do you need updated sunglasses (with or without prescription) to help protect your eyes from harmful UV light and to prevent Cataracts and Macular Degeneration?
- ❑ Do you need a **back-up pair** of prescription glasses? (For example, in case your current glasses are lost, or broken, or if there is an emergency where there is a fire or earthquake, etc)

Are you interested in spectacle lenses that:

- ❑ Darken in the sun? (transitions/photochromic)
- ❑ Reduce glare and reflections?
- ❑ Are thinner and lighter?
- ❑ Protect against harmful UV radiation?
- ❑ Protect against scratches?
- ❑ Are safety lenses for work?

Do you have the following?

- ❑ Children in need of an eye examination?
- ❑ Family members in need of an eye examination?

Are you interested in the following?

- ❑ Seeing better at night?
- ❑ Non-surgical vision correction?

Contact Lens History

- ❑ Currently wearing contact lenses.
  Brand and power _____
  Brand of solutions _____
  How often do you replace your lenses? _____
  How often do you sleep in your contacts? Never ____ Days/Week? _____

Are you interested in the following:

- ❑ Sleeping overnight in contact lenses?
- ❑ Bifocal contact lenses?
- ❑ Single use contact lenses that you don't need to clean?
- ❑ Contact lenses to change your eye color?
- ❑ Contacts for occasional use?
- ❑ A spare pair of Rigid Gas Permeable contact lenses?

Which of the following activities or hobbies do you enjoy?

Indoor Actvities	Indoor Actvities	Outdoor Activities	Outdoor Activities
❑ Card Playing	❑ Reading	❑ Basketball	❑ Running/Walking
❑ Computer	❑ Tv/Movies	❑ Biking	❑ Snow sports
❑ Knitting/Sewing	❑ _____	❑ Fishing	❑ Tennis
❑ Musical Instruments	❑ _____	❑ Gardening	❑ Water sports
❑ Pool	❑ _____	❑ Golf	❑ _____