

Burbank Family Optometry
1112 W. Burbank Blvd #204 Burbank, CA 91506
(818) 846-9075

Last Name _____ First Name _____ MI _____ Today's Date: _____
 Address _____ Martial Status: Single Married Divorced Widowed
 City _____ Zip Code _____ State _____ Age: _____ Date of Birth ____/____/____
 Telephone (CELL) _____ (Other:) _____ SSN # ____/____/____
 Date of last exam: ____/____/____ Last Physical: ____/____/____ Name of Medical Doctor: _____
 Occupation: _____ Hobbies: _____ Computer Use Hours: _____
 Email: _____ @ _____ May we text you? Yes/No

Vision Complaints: Blurred Distance/ Intermediate/ Near Headaches Redness Pain
 Itching Burning
 Floaters Dry eye None Other: PLEASE EXPLAIN: _____
 Do you wear glasses? Yes/No If yes, how old is current pair? _____
 Do you wear contacts? Yes/No If yes, how old is present pair? _____
 Are you interested in: New Glasses Sunglasses Contacts Other: _____
 Type of Contacts you wear? Soft Dailies 2Weeks Monthly Rigid Extended Wear
 Other: _____ Are they comfortable? Yes/No Please Specify: _____

Are you allergic to any Ocular/ Systemic medications? Yes/No Please specify: _____

Medical History: Please list all medications you are currently taking (including over the counter, vitamins and herbal therapy): _____

List all major surgeries (eye surgery included): _____

Please circle if any of the conditions to you or family member (blood relative only)

- Glaucoma YES NO WHO _____
- Macular Degeneration YES NO WHO _____
- Retinal Detachment YES NO WHO _____
- Cataracts YES NO WHO _____
- Corneal Problem YES NO WHO _____
- Eye Turn YES NO WHO _____
- High Cholesterol YES NO WHO _____
- Diabetes YES NO WHO _____
- High Blood Pressure YES NO WHO _____
- Cancer YES NO WHO _____
- Heart Disease YES NO WHO _____

Do you smoke? Yes/No Packs Per Day _____ Years Smoking _____
 Do you drink? Yes/No Social Use Only 1-2 Drinks Daily Above Average Use
 Are you pregnant? Yes/No Are you nursing? Yes/No

REVIEW OF SYSTEMS: *Please indicate below if you have or ever had problems with the following conditions*

Allergic/Immunologic

None
 Lupus (SLE)
 Seasonal Allergies
 Environmental Allergies
 Other: (i.e. Latex) _____

Cardiovascular

None
 High Blood pressure
 Heart Disease
 Vascular Disease
 High Cholesterol
 Other: _____

General Health

None
 Weight Gain/Loss
 Fever
 Trauma
 Fatigue
 Other: _____

Endocrine/Glands

None
 Diabetes (I or II)
 Hormone Dysfunction
 Thyroid Dysfunction
 Other: _____

Gastrointestinal

None
 Crohn's Disease
 Colitis
 Acid Reflux/ Ulcer
 Other: _____

Genital/Urinary

None
 Urinary Tract Infection
 HIV Positive
 Herpes/Chlamydia
 Other: _____

Ear/Nose and Throat/Head

None
 Sinusitis
 Upper Respiratory Tract Infection
 Headaches
 Other: _____

Hematologic/Lymphatic

None
 Anemia
 Leukemia
 Bleeding Disorder
 Other: _____

Skin/Integumentary

None
 Eczema
 Rosacea
 Psoriasis
 Other: _____

Muscle/Skeletal

None
 Arthritis
 Rheumatoid Arthritis
 Fibromyalgia
 Ankylosing Spondylitis
 Other: _____

Neurological

None
 Multiple Sclerosis
 Epilepsy
 Tremors
 Other: _____

Psychiatric

None
 Depression
 Bi-Polar
 Schizophrenia
 Anxiety
 Other: _____

Respiratory

None
 Asthma
 COPD
 Emphysema
 Other: _____

VERY IMPORTANT (NEW PATIENTS ONLY) Who may we thank for referring you to our office?

Internet: _____ Friend: _____ Other: _____

Lifestyle Question:

- Do you think you might benefit from thinner, lighter lenses? **Yes/No**
- Do you spend time outdoors? **Yes/No** How much? _____
- Do you prefer not to wear your glasses at times? **Yes/No**
- Do you have more than one pair of current prescription eyewear? **Yes/No**
- Do you have family members in need of eye care? **Yes/No**
- Do you have interest in a non-surgical approach to vision correction? **Yes/No**

Preferred Language (Circle One) English Spanish Armenian Other: _____

Race: (Circle One) African American Caucasian Hispanic Native American Hawaiian Asian Armenian

Ethnicity: (Circle One) Hispanic/Latin Not Hispanic Native American/Other: _____

Communication Preferred: (Circle One) Phone Email Text

Please sign below to acknowledge that this form is current

Signature: _____ Date: _____ Reviewd by Doctor's Initials _____

Signature: _____ Date: _____ Reviewd by Doctor's Initials _____

Signature: _____ Date: _____ Reviewd by Doctor's Initials _____