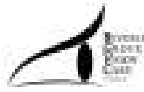

Beverly Grove Vision Care Optometry

Danielle T. Roth, O.D.
511 S. Fairfax Ave. LA, CA 90036
(323) 879-9259

Patient Information and Health History

Name: ______________________________________ Date: _______________________

Date of Birth: _______________ Age:________ Sex: M F Occupation: _____________

Student? Y N If yes, Grade? _______ Name of Employer/School: ________________________

Marital Status: ________________ Race/Ethnicity: __________________

Home Phone: (_____) ________________ Cell Phone: (_____) _________________

Work Phone: (_____) _________________ E-mail: _________________________

Home Address: ____

Who may we thank for referring you to our office? ____

What is your main reason for coming here today? ____
____

Check all that apply:

	You	Family
Allergies:	☐	☐
Diabetes:	☐	☐
High Blood Pressure:	☐	☐
Elevated Cholesterol:	☐	☐
Migraines:	☐	☐
Thyroid:	☐	☐
Cardiovascular:	☐	☐
Respiratory:	☐	☐
Cancer:	☐	☐
Drug Sensitivity:	☐	☐
Head Trauma:	☐	☐

	You	Family
Dry Eyes:	☐	☐
Color Vision Deficiency:	☐	☐
Cataracts:	☐	☐
Glaucoma:	☐	☐
Macular Degeneration:	☐	☐
Flashes/Floaters:	☐	☐
Eye Surgery:	☐	☐
“Lazy”/Turned Eye:	☐	☐
Retinal Detachment:	☐	☐
Blindness:	☐	☐
Eye strain:	☐	☐

How is your general health? ________________________ Are you pregnant or nursing? ________________
Date of last physical? _______________________ Date of last eye exam? _____________________
Do you smoke? _____________________ If yes, how often/how much? _____________
Do you drink alcohol? ___________________ If yes, how often/how much? _____________
Are you diagnosed with any medical or mental health conditions? Please list: ________________________
____

Please list all pills and medication you are currently taking: _______________________________________
____
____

Please list any allergies to medications: ____
____

Additional Vision Questions:

Who was your last eye doctor? ____

Please list any significant eye problems or eye surgeries you have had:_______________________________
____
____

Are you taking any eye drops/medications? ____

How many hours a day do you spend on digital devices (including your computer)? ______________

Do you wear glasses? _________ If yes, what do you use your glasses for? __________________________

How old are your current glasses? __________________

Do you wear contact lenses? _________ If yes, which brand do you wear? ______________

How often do you replace your contact lenses? _________ What disinfecting solution do you use? _________

Please circle any of the following symptoms you encounter while at work/school:

Headaches	Pulling sensation near eyes
Eyestrain	Red/watery eyes
Lose place while reading	Letters blur while reading
Get sleepy while working	Occasionally see double
Avoid certain tasks	Letters appear to swim on the page/screen

Please list any recreation/leisure activities: ____

Do you wear protective eyewear during sports? __________ Do you wear sunglasses? __________________