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Family and Developmental Optometry
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New Patient Information

Date: _____________

Welcome to our office! For first name us to effectively meet your vision and eye health needs, please complete the following:

Patient Information

Legal Last Name ______________________________ First__________________ MI ________
Preferred Name __________________________ Date of Birth__________________________

Sex assigned at birth ______________ Gender ______________ Pronouns ________________

Home Address____ City__________________ Zip_________

Phone No. Home( )_______________ Work( )_______________ Cell( )_______________

Email Address ____

We send out upcoming and annual appointment reminders via text and email. We also may send periodic news (like trunk shows and sales) regarding our practice. We will never release your information to outside parties.

May we contact you for:

Appointments via: (circle all that apply) *home work cell text email* News via email: *Yes No*

Occupation (or Grade)________________________ Employer (or School)________________________

If patient is a minor: Name of Parent/Guardian ____
Your relationship to patient (circle) *Mother Father Other:*

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

Vision and Health Insurance Information

Vision Care Insurance Carrier____________________________ Member ID#________________________

Medical Insurance Carrier____________________________ Member ID#________________________

Member Name:______________________________________Member Date of Birth___________________
Do you have Medicare? *Yes No* MediCal? *Yes No*
Method of payment you will use today (circle) *Cash Check Credit Card Care Credit*

I have read and understand the Notice of Privacy Practices for the office of Dr. Wendy Shem Yeh, O.D.

____ ________________________________

Signed (your name) Date

-Please see other side-

Patient Name:____

Medical/Vision Information

Approximate Date of your last Eye Exam (month/year)_________________

Briefly state your chief eye or vision concerns for your visit today __________________________________

____

Do you experience symptoms like dry, itchy, watery, burning eyes: *Yes* *No*

Do you experience symptoms of headache or migraines? *Yes* *No* How severe and often? ____________

Do you use a computer or digital device (tablet, phone)? *Yes* *No* How many hours a day? _________

Do your eyes feel tired, sore or uncomfortable when reading or do you ever lose your place or concentration when reading? *Yes* *No*

Do you wear contact lenses? *Yes* *No* If no, are you interested in Contact Lenses? *Yes* *No*

Do you wear sunglasses? *Yes* *No* If yes, what type(s): *Prescription* *Non-Prescription* *Clip-on*

Do you participate in any activities that put your eyes at risk for injury? *Yes* *No*

(i.e. racquetball, car repair, power tools, home repair etc.)

If yes, do you wear safety glasses? *Yes* *No*

Would you like information or are you interested in any of the following? (Please check)

- ❑ Vision Therapy for learning related visual problems
- ❑ Treatment to reduce or control nearsightedness progression (myopia control)
- ❑ Dry eye / Ocular aesthetics treatment
- ❑ Occupational / Workspace eyeglasses
- ❑ Refractive/Laser Eye Surgery to reduce your dependence on glasses/contact lenses

Primary Care Physician Name:___________________________ Date of Last Physical: ____________

Address/Phone:____

Medical Conditions:

Diabetes	Self	Family/Who_______________________________
Hypertension	Self	Family/Who_______________________________
High Cholesterol	Self	Family/Who_______________________________
Thyroid	Self	Family/Who_______________________________
Glaucoma	Self	Family/Who_______________________________
Macular Degeneration	Self	Family/Who_______________________________
Cataracts	Self	Family/Who_______________________________
Strabismus	Self	Family/Who_______________________________
Amblyopia	Self	Family/Who_______________________________
Other	Self	Family/Who_______________________________

Do you smoke?_____ How much?____

Medications:____

Medication Allergies:____

Other Allergies (food/environmental):____

Patient Signature:____Date:_______________

Parent/Guardian Signature if Patient is a Minor:____