Bay View Eye Care Center
1930 S. Bascom Ave. Ste. 210, Campbell, CA 95008
Patient History and Information

Name:_____
Vision Insurance Provider:_____
Medical Insurance Provider:_____

Date of last eye exam_____
Chief Complaint_____
Past Surgeries_____
Drug Allergies/ Sensitivities_____
Reaction_____
Current Medications_____
Major Illnesses or Injuries_____

CURRENT EYE SYMPTOMS

Asthenopic:	
Glare Sensitivity	YES
Headaches	YES
Light Sensitivity	YES
Tired Eyes	YES

Physiologic:	
Burning	YES
Dryness	YES
Epiphora (Watery Eyes)	YES
Eyelid Swelling	YES
Eye Pain or Soreness	YES
Foreign Body Sensation	YES
Infection of Eye Lid	YES
Itching	YES
Mucous	YES
Ptosis (Drooping Eyelid)	YES
Redness	YES
Sandy or Gritty Feeling	YES

Visual Symptoms:	
Blurred Vision Distance	YES
Blurred Vision Near	YES
Distorted Vision	YES
Double Vision	YES
Flashes of Light	YES
Floaters or Spots	YES
Fluctuating Vision	YES
Loss of Central Vision	YES
Loss of Side Vision	YES
Loss Of Vision	YES
Other	YES

Eye Diseases:	
Amblyopia (Lazy Eye)	YES
Blepharitis	YES
Blindness	YES
Cataract(s)	YES
Color Blindness	YES
Diabetic Retinopathy	YES
Dry Eye Syndrome	YES
Eye Injuries	YES
Glaucoma	YES
Glaucoma Suspect	YES
High Risk Medication	YES
Macular Degeneration	YES
PVD	YES
Retinal Detachment	YES
Strabismus (Eye Turn)	YES
Other	YES

REVIEW OF SYSTEMS:

Ears, Nose, Throat, Mouth	YES
Cardiovascular (high BP, etc.)	YES
Respiratory (asthma, etc.)	YES
Gastrointestinal	YES
Genital, Kidney, Bladder	YES
Muscles, Bones, Joints	YES
Skin (rash, skin cancer, etc.)	YES
Neurological	YES
Psychiatric (anxiety, etc.)	YES
Endocrine (diabetic, etc.)	YES
Blood/Lymph(cholesterol, etc.)	YES
Allergic/Immunologic	YES
Pregnant	YES
Nursing	YES

FAMILY HISTORY:

Eye Diseases:	
Amblyopia (Lazy Eye)	YES
Blindness	YES
Cataract(s)	YES
Colorblindness	YES
Eye Tumors	YES
Glaucoma	YES
Glaucoma Suspect	YES
Macular Degeneration	YES
Retinal Detachment	YES
Strabismus (Eye Turn)	YES

Systemic Diseases:	
Arthritis	YES
Cancer	YES
Diabetes	YES
Heart Disease	YES
High Blood Pressure	YES
Kidney Disease	YES
Lupus	YES
Stroke	YES
Thyroid Disease	YES

PLEASE CIRCLE:

Do you drink alcohol? NO / Occasional / 1 per day / 2-3 per day / 4+ per day
Do you smoke? NO / Occasional / 1/2 pack per day / 1 pack per day / 1+ pack per day
Computer used? YES / NO Hours per day_____ Do you wear contact lenses? YES / NO
Do you drive? YES / NO Do you have visual difficulty when driving? YES / NO
Do you have a glare problem? YES / NO Do you have any problems with night vision? YES / NO
Do you currently wear glasses? YES / NO Since_____ FULL TIME / PART TIME / DISTANCE / NEAR
GLASSES OWNED: Single Vision Progressive Bifocals Safety Glasses Sports Glasses Back-Up Glasses