1640 Arlington Ave. Torrance, CA 90501 | (310) 328-2020 Date: _____

CLARITY
OPTOMETRY

Patient's Name: _____ Date of Birth: ___/___/_____ Gender: ☐M ☐F
Last First Middle
Home Address: _____ Home Phone: (_____)_____-_____
City, State, Zip: _____ Cell Phone: (_____)_____-_____
Email Address: _____ What is the best way to contact you? _____
Occupation: _____ Employer: _____
How did you hear about our office? _____ If referred, by who? _____

INSURANCE INFORMATION

Do you have vision insurance? ☐Yes ☐ No If yes, name of vision insurance: _____

Name of Insured Member:_____ Relationship to patient: _____
Date of Birth: ___/___/_____ Social Security No: _____

Name of Medical Insurance: _____ ☐P.P.O ☐ H.M.O
Name of Medical Doctor: _____ Last Physical Exam: _____

MEDICAL HISTORY

List of all medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List any allergies to any medications:

_____
_____
_____

List all major injuries, surgeries, and/or hospitalizations:

_____
_____
_____

Are you currently pregnant or nursing? ☐Yes ☐ No

Please ☑ if you, or any family members, have been diagnosed with any of the following conditions:

Diabetes	☐Yes ☐No ☐Family_____	High Blood Pressure	☐Yes ☐No ☐Family_____
High cholesterol	☐Yes ☐No ☐Family_____	Heart Diseases	☐Yes ☐No ☐Family_____
Stroke	☐Yes ☐No ☐Family_____	Multiple Sclerosis	☐Yes ☐No ☐Family_____
Thyroid Disease	☐Yes ☐No ☐Family_____	Kidney Disease	☐Yes ☐No ☐Family_____
Lupus	☐Yes ☐No ☐Family_____	Arthritis	☐Yes ☐No ☐Family_____
Cancer	☐Yes ☐No ☐Family_____	Headaches/Migraines	☐Yes ☐No ☐Family_____

SOCIAL HISTORY

Do you drink alcohol? ☐Yes ☐No If Yes, ☐Occasionally ☐1 per day ☐2-3 per day ☐4+ per day
Do you use tobacco products? ☐Yes ☐No If Yes, ☐Occasionally ☐<1 pack/ day ☐1 pack/day ☐>1 pack/day

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EYE HISTORY

Do you wear glasses? ☐Yes ☐No If yes, how old is your current pair of lenses? _____
Do you drive? ☐Yes ☐No If yes, do you have any visual difficulty driving? _____
Do you wear contacts? ☐ Yes ☐No If yes, what brand of contacts? _____
Type of contacts: ☐Rigid ☐Soft ☐Other_____

Please ☑ if you or any family members have been diagnosed with any of the following eye conditions:

Amblyopia (lazy eye)	☐Yes ☐No ☐Family_____		Strabismus (eye turn)	☐Yes ☐No ☐Family_____	
Blindness	☐Yes ☐No ☐Family_____		Cataracts	☐Yes ☐No ☐Family_____	
Color Deficiency	☐Yes ☐No ☐Family_____		Glaucoma	☐Yes ☐No ☐Family_____	
Macular Degeneration	☐Yes ☐No ☐Family_____		Retinal detachment	☐Yes ☐No ☐Family_____	
Eye Injury	☐Yes ☐No ☐Family_____		Eye Surgery	☐Yes ☐No ☐Family_____	

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas: ☑ all that apply

	YES	NO
CONSTITUTIONAL		
Fever	☐	☐
Weight Loss/Gain	☐	☐
INTEGUMENTARY (skin)	☐	☐
NEUOLOGICAL	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES	☐	☐
Loss of vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching/Burning	☐	☐
Foreign body sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic infection of Eye or Eyelid-	☐	☐
Styes or Chalazion	☐	☐
Floaters and/or Flashes in Vision-	☐	☐
Tired eyes	☐	☐
BONES/JOINTS/MUSCLES	☐	☐
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐

	YES	NO
EARS, NOSE, MOUTH, THROAT	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY	☐	☐
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR	☐	☐
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY	☐	☐
Genitals/Kidney/Bladder	☐	☐
LYMPHATIC/HEMATOLOGIC	☐	☐
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNIOLOGIC	☐	☐
Seasonal/Hay fever	☐	☐
PSYCHIATRIC	☐	☐