Optometric Images - Vision Center
Dr. Gary K. Ozaki - Dr. Randall S. Ramsey
Welcome to Our Office

Today's Date: _____

General Information

Last Name_____ First Name _____MI____ Sex *M / F*
If minor, list parents names_____
Address_____ City_____ State _____ Zip_____
Work Ph (____)_____ Home Ph (____)_____ Cell Ph (____)_____
DOB_____ Occupation_____ Employer_____
Email_____ SSN_____
Emergency Contact Name_____ Phone Number_____
Referred by: *Yellow Pages Mailer Friends/Family Walk-by Insurance List Other*_____

Personal Eye Information

Date of Last Exam_____ Name of Doctor_____ Last Year of eye dilation_____
Reason for today's visit? *Routine Exam /Glasses New CL user exam Update CL Rx exam Medical Condition Other*_____
Have you had any eye operations? *Yes / No* Type_____ Date_____
Have you had an eye injury? *Yes / No* Kind_____ Date_____
Do you have Glaucoma? *Yes / No* Cataracts? *Yes / No* Dry Eyes? *Yes / No*
Macular degeneration? *Yes / No* Retinal detachment? *Yes / No* Blurred Vision? *Yes / No*
Do you wear glasses? *Yes / No* Contact Lenses? Yes / *No* If yes, *Soft / Hard*
Do you work on computers? *Yes / No* Hours per day? _____
Additional Problems:

Personal Medication Information

How is your general health? Any existing conditions or undergoing treatments?_____
_____
Do you have high blood pressure? *Yes / No* Diabetes? *Yes / No*
Current Medications? _____
Allergies to Medications? *Yes / No* Which?
_____
General Allergies? (ex. Pollen) *Yes / No* Do you suffer from dry eyes? *Yes / No*
Are the allergies causing redness, itching, or watery eyes that you need treated? *Yes / No*
Do you smoke? *Y / N* Alcohol Use? *Y / N* Other substances? *Y / N*

Family History

HBPressure? *Y / N* Relation_____ Macular Degeneration? *Y / N* Relation_____
Diabetes? *Y / N* Relation_____ Retinal Detachment? *Y / N* Relation_____
Glaucoma? *Y / N* Relation_____ Cataracts? Y / N Relation_____

Insurance / Payment

Do you have eye insurance? *Y / N*
Type: *VSP MES AVP EyeMed Medicare Davis Spectera Other*:_____
MAJOR MEDICAL INS:_____ ID# _____
Primary's Employer Name:_____
Primary's Name:_____ SSN: _____ DOB:

Payment is expected at the time of services