Family Vision Center

411 Primrose Road
Burlingame CA 94010

Date _____ Name _____ *Temp* *Oxygen*

Current home phone _____ Mobile phone _____

E-mail address for notifications _____

I have a change in home address _____

I have a change in employment _____

Do you have: fever, cough, shortness of breath, fatigue, loss of taste/smell, muscle aches Yes____ No____

Have you been in recent contact with anyone who has tested positive to Covid-19 Yes____ No ____

List any health issues _____

Medications _____

Is there a family history of: diabetes ___ glaucoma ___ macular degeneration___ retinal detachment ___

When was your last physical exam _____ If diabetic, what is your A1C _____

List any allergies to medications you have_____

Can we dilate your eyes today : Yes____ No____ If no, please initial _____

Have you suffered any recent injuries to the head or eyes: No ____Yes____ If yes, please describe below:

_____

What brings you to our office today: General exam___ Glasses___ Contact lenses___ Eye issue ___

Describe any problems that you have with your vision or eyes _____

_____

_____

Have you noticed any of the following: Sudden change in vision ___ Ocular pain ___ Dryness ___

Glasses can be made for certain activities. Would you be interested in glasses designed for these activities:

Golf ___ Fishing ___ Computer work___ Crafts ___ Machine work ___ Traveling ___ Reading___

Are you happy with the current glasses or contact lens prescription: Yes____ No____

If No, what changes would you like made _____

Will you be getting glasses here today _____ Do you need your prescription for an outside vendor _____

Thank you for being our patient.

Your referrals of friends and family are genuinely appreciated.