NGUYEN FAMILY VISION CARE OPTOMETRY CORPORATION
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Adult's Information Sheet

Name _____ Date of Birth_____
Address _____ Occupation_____
City/Zip Code_____ Business Name _____
Home Phone _____ Business Address _____
Work Phone_____ City/Zip Code_____

Spouse's Name _____ Home Phone _____
Business Name _____ Work Phone _____
Business Address_____ City/Zip Code_____

Which of the following Vision Insurance Plans are you covered by?
___ Vision Service Plan (VSP) ___ Medicare ___ Medi-cal ___ None of the Listed

What is the reason for the exam? _____

Which of the following Visual Symptoms do you have?

___	Eyes Cross or Turn Out	___	Blurred Distance Sight
___	Double Vision	___	Blurred Distance Sight After Reading
___	Eyes Become Red	___	Poor Night Vision When Driving
___	Headaches	___	Blurred Reading Sight
___	Eyes Itch	___	Must Hold Print Farther When Reading
___	Eyes Tear	___	Prescription Changes Each Year
___	Eyes Are Dry	___	Eyes Tire After Working on Computer
___	Eye Fatigue After Reading	___	Sensitive to Glare and Bright Light
___	See Flashes of Light or Floaters	___	Poor Visual Processing

What eye diseases run in your family? _____

Social History

Do you use tobacco products and/or drink alcohol? Y N
If yes, how often?_____
Do you use illegal drugs? Y N
If yes, type/amount/how long:_____
Have you ever been exposed to or infected with an STD?
(i.e. Hepatitis, Gonorrhea, Syphillis, HIV) Y N
If yes, type/how long: _____

Who referred you to our office? _____

___ I authorize the release of information ___ I do not authorize the release of information

Signature_____ Date _____