Lorina Leung, OD
408-738-2020

WELCOME TO FAMILY VISION CARE

454 East El Camino Real
Sunnyvale, CA 94087

Name: _____ Today's Date: ____ / ____ / ____

Address: _____Home Phone: _____

City, State & Zip: _____ Work Phone: _____

E-Mail Address: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Birth Date: ____ / ____ / ____ Gender: M or F
Last Eye Exam: ____ / ____ / May we text you appointment reminders? □ no □ yes
Name(s) and age(s) of family members living at home:

_____
Medical Doctor: _____ Phone: _____ Last Med Exam:____ / ____ / ____
Previous Eye Doctor: _____City:_____ Phone:_____

How did you hear about our office _____
Vision and Medical Insurance Information (Please show medical insurance card):
Member's Name: _____Relationship to Patient: _____
Date of Birth: ____ / ____ / ____ ID #_____Employer: _____
Vision Insurance: _____ Medical Insurance: _____

MEDICAL HISTORY:
Do you have any medication or environmental allergies? □ no □ yes If yes, explain _____

_____
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies) IF NONE WRITE NONE:

_____
List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injuries or eye surgeries _____
How many hours do you spend in front of a screen? _____
Are you pregnant and/or nursing? □ no □ yes
Do you wear glasses? □ no □ yes If yes, how old is your current pair ? _____
Do you wear contact lenses? □ no □ yes If yes, how old and what type are your current pair? _____
Are you interested in getting contacts and/ or a Contact lens exam: □ no □ yes
Would you like to be evaluated for LASIK: □ no □ yes
This information is kept strictly confidential.
Do you drive? □ no □ yes If yes, do you have visual difficulty when driving? □ no □ yes If yes, please describe:

_____
Do you use tobacco products? □ no □ yes If yes, type/amount/how long: _____
Do you drink alcohol? □ no □ yes If yes, type/amount/how long: _____ Do you use illegal drugs? □ no □ yes If yes, type/amount/how long: _____

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. I acknowledge that I have received the Notice of Privacy Practices from Dr. Leung.

X_____
Signature

Insurance Policy

I certify that I have insurance coverage with above stated provider, and assign to Dr. Leung all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

□ I do not have insurance (YOU DO NOT need to sign if no insurance applicable)

X_____
Signature

More on next page →

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Reason for visit today_____

Your health: CHECK ANY CONDITION THAT PERTAINS TO YOU(NOT YOUR FAMILY):

CONSTITUTIONAL
Cancer □ no □ yes
Disability □ no □ yes
Fatigue □ no □ yes

EARS, NOSE, MOUTH, THROAT
Hearing loss □ no □ yes
Sinusitis □ no □ yes
Dry mouth □ no □ yes

NEUROLOGICAL
Multiple sclerosis □ no □ yes
Epilepsy □ no □ yes
Cerebral palsy □ no □ yes
Tumor □ no □ yes
Migraine □ no □ yes
Autism □ no □ yes

PSYCHOLOGY
Depression □ no □ yes
ADHD □ no □ yes
Anxiety disorder □ no □ yes

CARDIOVASCULAR
Hypertension □ no □ yes
Stroke/CVA □ no □ yes
Heart disease □ no □ yes
Vascular disease □ no □ yes
Congestive heart failure □ no □ yes

RESPIRATORY
Cigarette smoker □ no □ yes
Asthma □ no □ yes
Bronchitis □ no □ yes
Emphysema □ no □ yes
Chronic Obstruction □ no □ yes
Sleep Apnea □ no □ yes

GASTROINTESTINAL
Crohn's □ no □ yes
Colitis □ no □ yes
Ulcer □ no □ yes
Acid Re flux □ no □ yes
Celiac Disease □ no □ yes

GENITOURINARY
Kidney Disease □ no □ yes
Prostate disease □ no □ yes
STD: herpes/chlamydia □ no □ yes

MUSCULOSKELETAL
Arthritis □ no □ yes
Osteoarthritis □ no □ yes
Fibromyalgia □ no □ yes
Muscular dystrophy □ no □ yes
Osteoporosis □ no □ yes
Gout □ no □ yes

INTEGUMENTARY
Eczema □ no □ yes
Rosacea □ no □ yes
Psoriasis □ no □ yes
Herpes Simplex/cold sores □ no □ yes
Herpes zoster/ Shingles □ no □ yes

ENDOCRINE
Type 2 Diabetes □ no □ yes
Type 1 Diabetes □ no □ yes
Thyroid dysfunction □ no □ yes
Hormonal dysfunction □ no □ yes

HEMOTOLOGY/LYMPHATIC
Anemia □ no □ yes
Ulcer □ no □ yes
Hypercholestermia □ no □ yes

IMMUNE SYSTEM
Drug allergies □ no □ yes
Rheumatoid Arthritis □ no □ yes
Lupus □ no □ yes
Sjogren's Syndrome □ no □ yes

EYES
Cataract □ no □ yes
Cross eyes (strabismus) □ no □ yes
Double vision □ no □ yes
Dry eyes □ no □ yes
Excess Tearing/watering □ no □ yes
Eye infection □ no □ yes
Eye pain or soreness □ no □ yes
Floaters or spots □ no □ yes
Glaucoma □ no □ yes
Inflammatory disorder □ no □ yes
Injury past or present □ no □ yes
Itchy eyes □ no □ yes
Keratoconus □ no □ yes
Lazy eye (amblyopia) □ no □ yes
Loss of vision □ no □ yes
Macular degeneration □ no □ yes
Patching □ no □ yes
Poor night vision □ no □ yes
Red eyes □ no □ yes
Retinal degeneration □ no □ yes
Retinal detachment □ no □ yes
Retinal hole □ no □ yes
SURGERY including lasik □ no □ yes
Tired eyes □ no □ yes

Other conditions not listed: _____
If Diabetic how long have you had diabetes and what was your last A1c:_____
If you had lasik how long ago did you have that done?_____
ALLERGIES: IF NONE WRITE NONE:_____

Family HISTORY: please note any family members (parents, grand parents, sibling or children; living or decease) for the following:

Diabetes □ no □ yes relation:_____
Macular degeneration: □ no □ yes relation:_____
Glaucoma: □ no □ yes relation:_____
Asthma: □ no □ yes relation:_____
Blindness: □no □ yes relation:_____
Thyroid Disease: □ no □ yes relation:_____
Cancer: □ no □ yes relation:_____
Lazy eyes: □ no □ yes relation:_____
Heart disease: □ no □ yes relation:_____
Kidney disease □ no □ yes relation:_____
High cholesterol: □ no □ yes relation:_____
Cataracts: □ no □ yes relation:_____
Other conditions: _____

Staff Use Only

_____
Doctor's Signature