

WELCOME TO OUR OFFICE

Dr. Murata &

ASSOC Nelson T. Murata, O.D.
 Christina M. Womack, O.D.
 Kathleen Buhler, O.D.
Doctors of Optometry



Today's Date _____

PATIENT Information

Last _____
 First _____ MI _____
 Street _____
 City _____ State _____
 Zip Code _____
 Primary Phone _____
 Alternate Phone _____
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Date of Birth _____ Age _____
 Sex M F
 Email Address _____
 Driver's License # _____
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT:

Whom may we thank for referring you to our office?
 Name of friend or relative _____
 If not referred, how did you choose our office?
 Another Dr. Insurance List
 Saw Sign/Building Web Page
 Yellow Pages: Which directory? _____
 Other _____

"The mission of Dr. Murata & Associates as a group of dedicated Eyecare professionals is to remain committed to the highest quality vision health care and consequent quality of life. We strive to offer in a timely manner: the best medical care as it pertains to vision, and the best ophthalmic devices, based on the specific needs of each patient. In each task that we undertake as doctors and staff, we shall be dedicated to our Mission, keeping this commitment foremost in our minds."

Insurance Information

Please note that insurance often does NOT cover the Contact Lens portion of your Evaluation.

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

Do you participate in a flex spending account?
 Yes No

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..use a computer more than two hours per day?
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs?
- ..spend time outdoors? Number of hours per day? _____
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children living at home?
- ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Glare problems at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

****The information in this confidential case history form is critical to the evaluation of your vision and health****

Patient Medical History	
Name of Family Physician _____ Date of Last Physical Check-up _____	
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____ _____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____	
Do you use (please circle) cigarettes/tobacco alcohol other substances?	
Have you been recently diagnosed or treated for the following health problems? Yes No	
(Constitution)	
Fever, sudden weight loss/gain	<input type="checkbox"/> <input type="checkbox"/>
(Cardiovascular)	
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
Heart problems	<input type="checkbox"/> <input type="checkbox"/>
Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
(Ear, Nose, Mouth, Throat) <input type="checkbox"/> <input type="checkbox"/>	
(Respiratory)	
Asthma	<input type="checkbox"/> <input type="checkbox"/>
"Cold/Flu" today	<input type="checkbox"/> <input type="checkbox"/>
(Gastrointestinal) <input type="checkbox"/> <input type="checkbox"/>	
(Genitourinary) <input type="checkbox"/> <input type="checkbox"/>	
(Musculoskeletal)	
Rheumatoid arthritis	<input type="checkbox"/> <input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/> <input type="checkbox"/>
(Integumentary - skin) <input type="checkbox"/> <input type="checkbox"/>	
(Neurological)	
Headaches	<input type="checkbox"/> <input type="checkbox"/>
Migraines	<input type="checkbox"/> <input type="checkbox"/>
(Psychiatric/Psychological)	
Anxiety	<input type="checkbox"/> <input type="checkbox"/>
Depression	<input type="checkbox"/> <input type="checkbox"/>
Insomnia	<input type="checkbox"/> <input type="checkbox"/>
Other: _____	<input type="checkbox"/> <input type="checkbox"/>
(Endocrine)	
Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>
(Hematologic/Lymphatic)	
Anemia or bleeding problems	<input type="checkbox"/> <input type="checkbox"/>
(Allergies/Immunologic)	
Sinus/Hayfever	<input type="checkbox"/> <input type="checkbox"/>
Are you pregnant/nursing?	<input type="checkbox"/> <input type="checkbox"/>
Cancer <input type="checkbox"/> <input type="checkbox"/>	
Type of cancer and when _____	

Patient Eye History
When was your last Eye Exam? _____ By whom? _____
Have you ever had EYE surgery ? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Surgery Procedure Surgeon _____
~~~~~
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind? _____ Solutions used: _____ Time of day you usually <b>insert</b> your contacts: _____ Time of day you usually <b>remove</b> your contacts: _____ Do you wear your contacts overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No How long does <b>each pair</b> of your contact lenses last, before you replace them? _____ How old is the pair you're currently wearing? _____
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No ~~~~~
If you wear bifocal glasses, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No

Family Medical/Eye History
Is there a family medical history of any of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No
(Please check all that apply, and indicate <b>which blood relative(s)</b> has or had the condition)
Glaucoma <input type="checkbox"/> _____
Macular Degeneration <input type="checkbox"/> _____
Retinal problems <input type="checkbox"/> _____
Blindness <input type="checkbox"/> _____
Strabismus (eye turn) <input type="checkbox"/> _____
Amblyopia (lazy eye) <input type="checkbox"/> _____
Heart Disease <input type="checkbox"/> _____
Diabetes <input type="checkbox"/> _____
Other Disease <input type="checkbox"/> _____

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