Craig W. Hoeft, O.D.
12661 Glenoaks Blvd.
Sylmar, CA. 91342
(818) 367-2171

TODAY'S DATE____________________

Name____ **CELL #**__________________**HOME#**__________________
Address____City______________________ State_____ Zip____________
Birthdate____________SSN#____-____-_____Occupation__________________________Last eye exam ____ /________
Last Physical __ /_______ Primary Physician_____________________________Telephone______________________
Computer Use Hrs_______Cell_______TV_______Outside_______Hobbies__________________________________

<u>CHIEF COMPLAINT:</u> (CIRCLE ALL THAT APPLY) **DRY** **BURN** **ITCH** **RED**
COMPUTER-BLUR **DIST-BLUR** **NEAR-BLUR** **FLOATERS** **HEADACHES**
OTHER EXPLAIN____

Do you wear Glasses? YES NO If YES. How old is current pair?__________________________
Do you wear Prescription Sunglasses? YES NO If YES. How old is current pair?__________________________
Do you wear Non Prescription Sunglasses? YES NO If YES. How old is current pair?__________________________
Do you wear Contact Lenses YES NO How old is current pair you're wearing?______________________
Type of Contact Lenses you wear? **DAILY** **BI-WEEKLY** **MONTHLY** **QUARTERLY** **YEARLY**

<u>MEDICAL HISTORY:</u>
CURRENT MEDICATIONS (including over the counter vitamins and herbal therapy):________________________
____
____
MAJOR SURGERIES(systemic and ocular)____
<u>Are you ALLERGIC to any Systemic or Ocular medications?</u> YES/NO What?______________________________

<u>CHECK ALL THAT APPLY TO YOURSELF:</u>

<u>Disease/Condition</u>	**<u>Yourself</u>**	
Glaucoma	YES	NO
Macular Degeneration	YES	NO
Retinal Detachment	YES	NO
High Cholesterol	YES	NO
Diabetes	YES	NO
High Blood Pressure	YES	NO
Cancer	YES	NO

Are you pregnant? YES NO
Are you nursing? YES NO

Do you smoke? YES/NO packs/day______Yrs. Smoking______
Do you drink? YES/NO **Social Use Only** **1-2 drinks daily**
Above average Use

<u>FAMILY MEMBER</u>			**<u>RELATIONSHIP(blood relative only) (mother's or father's side)</u>**
Eye Turn	YES	NO	Who ________________________________
Glaucoma	YES	NO	Who ________________________________
Retinal Problems	YES	NO	Who ________________________________
Macular Degeneration	YES	NO	Who ________________________________
Retinal Detachment	YES	NO	Who ________________________________
Corneal Problems	YES	NO	Who ________________________________
Cataract	YES	NO	Who ________________________________
High Blood Pressure	YES	NO	Who ________________________________
Heart Disease	YES	NO	Who ________________________________
High Cholesterol	YES	NO	Who ________________________________
Diabetes	YES	NO	Who ________________________________
Cancer	YES	NO	Who ________________________________

REVIEW OF SYSTEMS Please indicate below if you have or ever had problems with following conditions:

Allergic/Immunologic
____None
____Lupus (SLE)
____ Rheumatoid Arthritis
____Seasonal Allergies
____Environmental Allergies
Other (i.e., Latex)___________

Cardiovascular
____None
____High Blood Pressure
____Heart Disease
____Vascular Disease
____High Cholesterol
Other_________________

General/Health
____None
____Weight Loss/Gain
____Fever
____Trauma
____Fatigue
Other_______________

Endocrine/Glands
____None
____Diabetes
____Hormone Dysfunction
____Thyroid Dysfunction
Other_________________

Psychiatric
____None
____Depression
____Bi-Polar
____Schizophrenia
____Anxiety
Other_______________

Genital/Urinary
____None
____Urinary Tract Infection
____HIV Positive
____Herpes/Chlamydia
Other________________

Hematologic/Lymphatic
____None
____Anemia
____Leukemia
____Bleeding Disorder
Other__________________

Skin/Intergumentary
____None
____Eczema
____Rosacea
____Psoriasis
Other________________

Muscle/Skeletal
____None
____Arthritis
____Fibromyalgia
____Ankylosing Spondylitis
Other_________________

Neurological
____None
____Multiple Sclerosis
____Epilepsy
____Tremors
Other_____________

Respiratory
____None
____Asthma
____COPD
___Emphysema On Set________
Other______________________

Gastrointestinal
____None
____Crohn's Disease
____Colitis
____Acid Reflux/Ulcer
Other_________________

Ear/Nose and Throat/Head
____None
____Sinusitis
____Upper Respiratory
____Headaches
____Migraine On Set_________

Lifestyle Questions:

____Do you think you might benefit from thinner, lighter lenses?
____Do you prefer not to wear your glasses at times?
____Do you have family members in need of eyecare?
____Do you have prescription sunwear?
____Do you have more than 1 pair of current Rx eyewear?
____Do you have interest in a non-surgical approach to vision correction?

Preferred Language: English Spanish Other_________________________________

Race: (circle one) Native American/Native Alaskan Hawaiian/Other African American Hispanic Caucasian Asian

Ethnicity: (circle one)
Hispanic/Latino Native American/Other Pacific Island Not Hispanic/Latino

Communication Preferred:
Email____ Telephone Text

(NEW PATIENTS ONLY) Who may we thank for referring you?
Internet_______Friend_________________________________Other____

Please sign below to acknowledge that this form is current:

Signature____**Date**______________ **Reviewed by Doctor's initials**_______
Signature____ **Date**______________**Reviewed by Doctor's initials**_______
Signature____ **Date**______________**Reviewed by Doctor's initials**_______