Downtown L.A. Vision Center
623 W. 6th St.
Los Angeles, CA 90017

PATIENT INFORMATION - Please Complete at Each Annual Examination (Please Print)

☐ Mr. ☐ Master ☐ Mrs. ☐ Dr. ☐ Ms.	Last Name	First Name	Initial	SEX ☐ Male ☐ Female	Birthdate	Age

Home Address	City	State	Zip	Home Phone	Work Phone

Employer Name	Employer Address	City	State

Social Security Number	Your Occupation	Referred By	Signature (If under 18, parent signature required)

Will you be using any vision benefits or programs? ☐ No ☐ Yes If yes, please fill in the information below.

Vision Plan Name	Member ID #	Insured's Name	Patient's Relationship to Insured

We will file an insurance claim for any plan under which we are providers. If you have a question about which plans for which we are providers, please ask the receptionist. Payment is expected at time of treatment.

RETURNING PATIENT ONLY

I have reviewed my previous history and acknowledge there is no change	Signature (If under 18 years of age, parent signature required)	Date

Please indicate any changes below.

PATIENT HISTORY

1. Do you have? (please check all that apply)
   - ☐ eyestrain ☐ pain ☐ double vision
   - ☐ dry eyes ☐ itchy eyes ☐ blurred vision with glasses or contacts
   - ☐ floaters ☐ flashes of light ☐ severe or frequent headaches
   - ☐ frequent neck and shoulder pain
2. Name of your primary physician: ____________ Date of last physical: ________ HMO Member? ☐ No ☐ Yes
3. Age of present glasses: ____________ Date of last eye exam: ____________
4. Have you been examined at Downtown Vision Center before? ☐ No ☐ Yes When: ____________
5. Have your eyes been dilated before? ☐ No ☐ Yes When: ____________
6. Have you had retinal photographs taken before? ☐ No ☐ Yes When: ____________
7. Do you or any blood relatives (grandparents, parents, brothers, sisters, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal disease	☐	☐	high blood pressure	☐	☐
cataracts	☐	☐	thyroid problems	☐	☐
glaucoma	☐	☐	asthma	☐	☐
diabetes	☐	☐	lung disease	☐	☐
high cholesterol	☐	☐	heart disease	☐	☐

8. Are you pregnant? (if applicable) ☐ No ☐ Yes
9. Are you being treated for any medical condition? ☐ No ☐ Yes Please List ____________
10. Are you taking any medications? ☐ No ☐ Yes Please List ____________
11. Are you allergic to any medication including eye drops? ☐ No ☐ Yes Please List ____________
12. Do you have or have you ever had any eye disease, injury or surgery? ☐ No ☐ Yes

    If yes please explain: ____________