Please print and fill out form and bring to your appointment

PATIENT HISTORY FORM

*WELCOME TO OUR OFFICE!
*PLEASE TAKE A MOMENT TO FILL OUT THIS FORM.

Patient Information

Patient Name Date

Reason for today's visit _____
Have you ever had any eye injury or surgery ? _____
General Health? (circle one) Good Fair Poor
Have you ever had double vision, floaters or flashes? _____
When was your last visit to the eye doctor? _____
Have you ever had a dilated eye exam? _____
Current medications? _____
_____
Medication allergies or sensitivities? _____
Environmental allergies or sensitivities? (hay fever, latex, etc) _____
Do you currently wear glasses or contacts? _____

*For Yourself or any Blood Relative, is there a history of:
If selected, please explain (WHO, etc)

□Glaucoma _____
□Cataracts _____
□Macular degeneration _____
□Retinal disease or detachments _____
□Crossed or lazy eye _____
□Other eye diseases _____
□Diabetes _____
□Heart disease, hypertension _____
□Multiple Sclerosis _____
□Crohn's Disease _____
□Arthritis _____
□Asthma, respiratory disease _____
□Systemic Lupus _____
□Other immune system conditions_____
□Anxiety or psychological conditions _____
□Currently smoking? _____
□Pregnant ? _____nursing?_____

*Attestation: The information provided is true and complete to the best of my knowledge. If any of this information should change, I will notify my office promptly.

Patient Signature _____ Date _____

For Office Use Only

Review date _____Provider signature _____
Review date _____Provider signature _____
Review date _____Provider signature _____

20/20 Vision Center

providing concerned, professional family eye care

Welcome to the office of Dr. J. Michael Vidal!

7090 Parkway Drive (619) 460-2020
La Mesa, CA 91942 www.2020lamesa.com

How did you hear about us? _____ **Patient Signature** _____
(Or Guardian)

Patient Name _____ **Birth Date** _____
Last First Middle

Address _____ **Home Phone** _____
Street City Zip Code **Cell Phone** _____

Patient employed by _____ Work Phone _____ Occupation _____

Insurance ID No. _____ SSN _____ Driver's Lic. No. _____

Responsible party _____ Relation to patient _____
(Self or Guardian) Full Name

Address of responsible party _____ Phone _____
(If different from above)

Name of Spouse _____ Employed by _____Work Phone _____