Dr. Paul S. Crismon Optometry

13800 San Antonio Dr.
Norwalk, CA 90650

Welcome to Our Office

Name: (Mr. Mrs. Ms) ____________________

Street: ____________________

City: __________ State: ________ Zip: ________

Cell Phone ____________________

Home Phone ____________________

Work Phone ____________________

Social Security Number: ____________________

Driver's Lic. # ____________________

Employer ____________________

Occupation ____________________

How were you referred to our office? ____________________

Email Address: ____________________

How long since last eye exam __________ Sex: Male Female

DOB ________ Age ______ Pregnant or Breast Feeding? Yes No

Spouse (or parent) name ____________________

Spouse (or parent) work phone ____________________

Medical insurance ____________________

Company ____________________

Vision insurance ____________________

Do you participate in a Flex Spending Account? **Yes** **No**

Diagnostic Issues

Main Purpose of eye exam:
(ie. Routine Check-up, Blurriness near or far, Update Contacts, etc.)

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Do You Experience...

(Please Circle)

- Any discomfort with your eyes? **No Yes**
- Problems with glare or reflection? **No Yes**
- Sensitivity to light? **No Yes**
- Chronic or recent Headaches: (circle) **No Yes**
- Floaters or flashes of light: (circle) **No Yes**
- Any problems with your current glasses or contacts?

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- Do you have more than 1 pair of current Rx glasses? **No Yes**
- Protective eye wear? **No Yes**
- Do you work on a computer for long periods? **No Yes**
- If you wear glasses, would you benefit from thinner, lighter lenses? **No Yes**
- Do you spend a lot of time outdoors or in sports? **No Yes**
- Do you experience any problems with current eyewear? **No Yes**
- Are there times you'd rather not wear glasses? **No Yes**
- Are you interested in a "test drive" of the latest in contact lenses design(s)? **No Yes**
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation? **No Yes**

Personal & Family Medical History

Please circle if you or someone in your family has

Allergies	Self	Family	Glaucoma	Self	Family
Asthma	Self	Family	Eye Diseases	Self	Family
Arthritis	Self	Family	Heart Diseases	Self	Family
Cancer	Self	Family	Eye Injury	Self	Family
Eye Surgery	Self	Family	High Blood Pressure	Self	Family
Cataracts	Self	Family	Diabetes	Self	Family

Cigarettes	**No**	**Yes**
Tobacco	**No**	**Yes**
Alcohol	**No**	**Yes**

Other Substances ____________________

Current Medications

(Rx & Over-the-Counter)

			Name of Medication
Antihistamines	No	Yes	
Diuretics (water pills)	No	Yes	
Blood Pressure pills	No	Yes	
Oral Contraceptives	No	Yes	
Diabetes Med	No	Yes	
Eye Drops	No	Yes	
Cholesterol	No	Yes	
Other:	No	Yes	

Are you currently under the care of a physician? **No** **Yes**

Name of Physician ____________________

Full Payment is due before any materials can be ordered or released.

Any order that is cancelled will result in a 25% restocking fee.

Method of payment:

□ Cash □ Visa □ MasterCard □ American Express □ Care Credit

____________________ ____________

Signature/Parent Signature (*if pt. is a minor*) **Date**