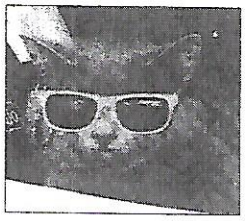

Welcome to our Office

Date _____

Dr. Cameron T. Yee, O.D.
6407 Riverside Blvd.
Sacramento, CA 95831
(916) 395-0673

Please take a few moments to complete the following information for our records. Thank you.

Personal Information

☐ Mr.
☐ Mrs.
☐ Ms. First Name _____ Last Name _____ M.I. ____
Address _____ City _____ State ____ Zip _____
Cell # _____ Home # _____ Wk# _____
Employer _____ Birthday ___/___/___ Age _____
E-Mail (Optional) _____

****

Insurance Carrier _____ Insure's I.D. # *(last 4 digits of SSN)* _____
Insure's Name _____ Insure's Birthday ___/___/___
**2nd Insurance Carrier* _____ *Insure's I.D. #* _____
Insure's Name _____ *Insure's Birthday* ___/___/___
Preferred Method Of Payment ☐ Cash ☐ Credit / Debit
Who referred you to our office? _____
Person to contact in case of emergency _____ Phone # _____

****

Vision History

* If you wear glasses/contact lenses, how old is your most recent pair _____ years.
* When was your last routine eye examination? _____ years.
* Is this a routine eye examination? If not, what problems are you having? _____

_____

* Any history of eye injury/surgery? If yes, please explain _____

_____

Please check if you are having any problems listed below.

Yes	No		Yes	No		Yes	No	
☐	☐	Headaches	☐	☐	Poor Distance Vision	☐	☐	Red Eyes
☐	☐	Double Vision	☐	☐	Poor Close Vision	☐	☐	Watery Eyes
☐	☐	Floaters/Spots	☐	☐	Poor Night Vision	☐	☐	Itchy Eyes
☐	☐	Flashing Lights	☐	☐	Allergies	☐	☐	Sore Eyes
☐	☐	Dimming of Vision	☐	☐	Difficulty Focusing From Far to Near	☐	☐	Sharp Pain in Eyes
☐	☐	Sensitive to Sunlight						

Your Medical History

Since some general body diseases can affect our eyes, please check any disease listed below that you have/had.

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Cataracts	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Eye Surgery	☐	☐	Macular Degeneration
☐	☐	Heart Disease						

What medication are you allergic to _____
What medications do you take _____

Family Medical History

Since some diseases can be inherited, please check any disease listed below that your Parents, Grandparents, Aunts, Uncles, Brothers or Sisters have/had.

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Cataracts
☐	☐	Diabetes	☐	☐	Glaucoma	☐	☐	Eye Surgery