Redondo Optometry
Dr. Sandy Hokama, Dr. Tiffany Ong
249 Avenida Del Norte
Redondo Beach, CA 90277
310-540-6225

Patient Information Questionnaire

Last Name: _____First Name: _____MI:_____

Address:_____ Apt#:_____
City: _____ State:_____ Zip:_____
Cell Phone:_____ Home Phone:_____
Work Phone: _____ Email:_____
Date of Birth:_____ Age:____ Occupation:_____ Employer:_____
Emergency Contact Name:_____ Contact Number:_____
Date of Last Eye Exam:_____ Dilated? Yes/No Referred by:_____
Vision Insurance:_____ ID#_____
Medical Insurance:_____ ID#:_____ Group #:_____
Name of Primary Member on Insurance:_____ DOB of Primary:_____

Medical Information
Chief Complaints:_____
Do you take medications for any of the following? (circle yes or no)

Gastrointestinal	Yes/No	Muscles/Bones	Yes/No	Endocrine (glands)	Yes/No
Cardiovascular	Yes/No	Eyes	Yes/No	Allergic/Immunologic	Yes/No
High Blood Pressure	Yes/No	Headaches	Yes/No	Mental	Yes/No
Cholesterol	Yes/No	Respiratory	Yes/No	**Seizures**	**Yes/No**

Please explain_____
Diabetes Yes/No_____ Type:_____ Date of diagnosis:_____
Allergies to Medication (s) Yes/No Which:_____ Reactions:_____
Other Health Problems_____
Current Medication (s)_____
Have you had any operations? Yes/No Kind?_____ When?_____
Name of family doctor and/or primary care physician_____
Date of last visit: _____ Date your blood pressure was last checked:_____

Family History

High blood pressure	Yes/No	Relation_____	Diabetes	Yes/No	Relation_____
Macular degeneration	Yes/No	Relation_____	Glaucoma	Yes/No	Relation_____
Retinal detachment	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information
Do you have any eye conditions or problems? Yes/No Kind? _____
Have you had any eye operations? Yes/No Type_____ Date_____
Have you had an eye injury? Yes/No Kind_____ Date_____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred Vision?	Yes/No
Do you smoke?	Yes/No	Drink Alcohol?	Yes/No	Take recreational drugs	Yes/No
Do you wear glasses?	Yes/No	Contact Lenses?	Yes/No	How old are your glasses	_____

Signature:_____ Date:_____