Redondo Optometry
Sarah Frassato, O.D.
249 Avenida del Norte
Redondo Beach, Ca 90277

Returning Patient Information
Last Name _____ First Name _____ MI: _____
Address _____Apt #_____
City: _____State_____ Date of Birth _____ Age_____
Cell Phone: _____Home phone _____Email _____

Are you experiencing any of the following symptoms?

Blurry vision	☐Yes ☐No	Floaters	☐Yes ☐No
Computer related eye strain	☐Yes ☐No	Flashes of light	☐Yes ☐No
Dry Eyes	☐Yes ☐No	Double vision	☐Yes ☐No
Itchy Eyes	☐Yes ☐No	Frequent headaches	☐Yes ☐No
Other_____			

Medical Information:

Do you have a history of seizures? ☐Yes ☐No

Are you taking medication for any of the following?

Cardiovascular	☐Yes ☐No	Muscles/Bones	☐Yes ☐No	Allergic/Immunological	☐Yes ☐No
Hypertension	☐Yes ☐No	Respiratory	☐Yes ☐No	Genitourinary	☐Yes ☐No
Diabetes	☐Yes ☐No	Endocrine (glands)	☐Yes ☐No	Neurological	☐Yes ☐No
Cholesterol	☐Yes ☐No	Gastrointestinal	☐Yes ☐No		

Medical history: List any medical conditions or past surgeries:	**Medications:** List any medications including dosage:	**Allergies:** List any mediation allergies and reactions:
Ocular history: List any eye conditions or past injuries:	**Ocular surgery:** List type of surgery/ date/ surgeon:	**Eye drops:** List any eye drops that you are using:

Family Ocular history:

Glaucoma ☐Yes ☐No relation_____

Macular degeneration ☐Yes ☐No relation_____

Retinal detachment ☐Yes ☐No relation_____

Other _____

Family Medical history:

Diabetes ☐Yes ☐No relation_____

Hypertension ☐Yes ☐No relation_____

Heart disease ☐Yes ☐No relation_____

Primary Care Physician:	**Other Specialist:**

Social History:

Occupation:	**Hobbies:**

Do you smoke cigarettes: ☐Yes ☐No If yes, for how long?

Do you drink alcohol: ☐Yes ☐No If yes, how many per day? Per week?

Do you use recreational drugs: ☐Yes ☐No

Signature: _____ Date: _____