Welcome to Our Office

Dr. Jennifer Kao, O.D. and Associates

(Please Print) Today's Date_____

_____ _____ _____ SEX M / F

Patient's Last Name **First Name** **MI**

Address_____ City_____ Zip_____

Home Phone(___)_____Work(___)_____Other(___)_____

Occupation _____ Employer/School &Grade_____

Birthday_____ SS #_____ Email _____

Whom May We Thank for Refering you to this Office_____

VISION Insurance _____Medi-care/Medi-cal#_____

Primary Insured Member_____Member's SS/ID #_____

Fluent Language: English Chinese: Mandarin Vietnamese Other_____
(Please Circle) Cantonese

OFFICE POLICY: A MINIMUM DEPOSIT OF ONE HALF ON YOUR BALANCE MUST BE PAID WHEN PRESCRIPTION IS ORDERED. BALANCE IS DUE UPON DELIVERY.

Patient Health History

Date of last eye exam_____ Eye Doctor_____
Date of last health exam_____Primary Family Doctor_____
Have you ever had: **Glasses? Y / N** For How Long? _____
Contact Lenses? Y / N Type_____How Long? _____If NO, are you interested?_____
Laser Eye Correction (LASIK) Surgery? Y / N When?_____If NO, are you interested?_____
Any type of Eye Surgery? Y / N Type _____ Date_____
Have you been treated for any eye diseases or eye injuries? **Y / N** Type _____
Date of treatment _____Eye Drops currently using _____
Are you in good health? Y / N Medical Problems?_____
Have you ever had any operations? Y / N What kind?_____
Present Medications _____Reason_____
Medications you are allergic to_____
Do you use: Cigarettes/ Tobacco? **Y / N** Alcohol? **Y / N** Other Substances? Y/ N_____
Do you have any of the following conditions:

___Diabetes 糖尿病 ___Cataract 白內障 ___Headaches 頭痛 ___Allergies 過敏
___High Blood Pressure 高血壓 ___Red or Watery Eyes 血絲/流淚 ___Double Vision 雙影 ___Itchy Eye 眼睛癢
___Glaucoma 青光眼 ___Sensitive to Light 懼 光 ___Eye Strain 眼睛疲勞 ___Dry Eyes 乾眼症

Do you have blurred vision? **Y / N** Other types of Eye Problems? _____

Family Health History

Please List Relation of Family Member who has had:
High Blood Pressure? _____ Glaucoma? _____
Diabetes? _____ Other Eye Conditions? _____
Has anyone in your family visited our office? Y / N Who? _____
Special visual requirments at work/ school: Computer_____ Microscope _____Other_____
Sports you actively participate in:
Basketball _____Tennis _____ Golf ____Swimming ____Baseball _____Soccer_____Other _____
Additional Information: _____