

LUM OPTOMETRY
Randall T. Lum, O.D.
WELCOME TO OUR OFFICE

Name _____ Mr. Mrs. Ms. Middle Initial _____ Sex: M / F
Address _____ City _____ Zip _____
Phone (Home) _____ (work) _____ (cell) _____
Insured SS# _____ D.O.B. _____ Age _____ E-Mail _____
Occupation _____ Employer _____ If student: Grade _____
Date of last eye exam _____ Age of glasses _____ Age of contacts _____ Last Doctor's name _____

Do you or any family members have any of the following?

Diabetes	Y / N who _____	Glaucoma	Y / N who _____
High Blood Pressure	Y / N who _____	Retinal Detachment	Y / N who _____
Thyroid	Y / N who _____	Macular Degeneration	Y / N who _____
Heart Problems	Y / N who _____	Blindness	Y / N who _____
Asthma	Y / N who _____	Eye turn / Lazy	Y / N who _____
Dry / Watery Eyes	Y / N who _____	Cataracts	Y / N who _____

Medical Insurance Name: Kaiser / Blue Cross / PPO / Blue Shield **Other** _____

Are you taking any medications? If so, for what problems? Y / N HTN / Chol / Diab / Thy

List Medications: _____

Do you have any allergies or allergies to food/ medication? Y / N **List** _____

Have you ever had an eye infection, disease, injury or surgery? Y / N **List** _____

Do you notice double vision/ floaters/ flashes of light? Y / N **When?** _____

Do you get frequent headaches? Y / N **When?** _____

Do you get motion sickness / fall asleep reading? Y / N **When?** _____

Are you / have you ever been a cigarette/ alcohol/ substance abuser? Y / N **Which?** _____

Do you work on a computer? Y / N _____ **Hours per day?**

What sports / hobbies do you enjoy? _____

Are you interested in contacts lenses? Y / N

Do you now wear contact lenses? Y / N

Does anybody in your immediate family wear glasses or contacts? Y / N

How did you hear about our office? VSP list / Yellow pages / Postcard / Referred By _____

Reason for Eye Exam? Blurred @ Near/Distance; Lost/Broken/Scratched Glasses; Routine Exam; Other _____

How will you be paying for your examination, glasses, or contacts today? Check Cash Charge Debit