WELCOME TO OUR OFFICE!
DR. WILLIAM K. SHIOMI
OPTOMETRIST

Email: _____ Today's Date _____

Patient Name (Circle One) Mr. Mrs. Ms. Last _____ First _____

Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ Residence Phone _____

Occupation _____ Best Contact # _____

Employer _____ If student: Grade _____ School _____

Approximate date of last eye examination _____ First visit to this office? _____ Yes _____ No

Referred by _____

Name of Parent or Spouse _____

Approximate date you received your current eyeglasses _____

Do you feel a change is needed in your prescription to see clearly at:
Distance _____ Yes _____ No Near _____ Yes _____ No

Driver's Lic. No. _____ Soc. Sec. No. _____

Do you wear your eyeglasses all the time: _____ If not,when? _____

Please complete the following: GENERAL HEALTH: PAST OR PRESENT

_____ Allergies
_____ Asthma
_____ Diabetes
_____ Fainting
_____ Hay Fever
_____ Drug Sensitivities
_____ High Blood Pressure
_____ Skin Conditions
_____ Surgical Operations
_____ Eye Diseases
_____ Eye Surgery
_____ Eye or head injuries
_____ Glaucoma, blood relatives who have
_____ Headaches
When do you get them _____
Where do they hurt _____

Family History

Has anyone in your family had:

_____ Diabetes
_____ Heart Disease
_____ Blindness
_____ Eye Diseases
_____ Strabisumus (Crossed eyes)
_____ To Wear Spectacles

If presently taking medications, please state which ones _____

_____

Date of last general health exam _____ Physician _____

Any abnormalities reported from this exam? _____

_____

Are you currently experiencing any problem with your eyes or vision? _____ How Often? _____

Have you ever worn contact lenses? _____ If yes, when were they prescribed? _____

Do yo wear contact lenses now? _____ If not, why did you quit? _____

_____

_____

Are you interested in contact lenses? _____