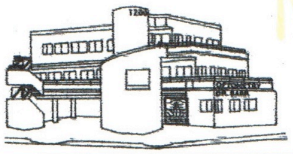
Kenneth Chu OD
1200 Artesia Blvd. #1
Hermosa Beach, CA 90254



LET'S GET ACQUAINTED!

Dr. Kenneth Chu is a native of the Southern California. He graduated from Rio Mesa High School, U.C.L.A., and the Illinois College of Optometry. Dr. Chu's primary concern is your visual health and well being. If you enjoy the level of care we provide, please tell others. Thank you for choosing us for your eye care and taking the time to complete the following.

You may notice your signature is required in multiple places in order for us to comply with Federal legislation.

Last Name:_____ Birth _____/_____/_____

First Name:_____ Mid. Initial _____ Soc. Sec. _____

Preferred Nickname:_____ Sex: M F

(circle): Miss Mrs. Ms. Mr. Dr. Rev. _____? e-mail _____

Street:_____ Employer (or School)_____

City:_____ Occupation (or grade)_____

State:_____ Zip:_____ If patient is a minor, parent or guardian:_____

Home Phone: ( ) _____-_____ Ext:_____ Family Physician _____

Work Phone: ( ) _____-_____ Ext:_____ _____

How did you hear about our office?_____

The major reason for your visit today is:

_____Yearly Exam
_____Distance Vision Blurry
_____Close Up Vision Blurry
_____Headaches
_____Eye Strain
_____Red Eyes
_____Watery Eyes
_____Dry Eyes
_____Itchy eyes
_____Light Sensitive
_____Light Flashes
_____Floaters
_____Other_____

We will consider both your work and recreational vision needs in our prescription recommendations.

Do you spend time on:
_____Computers (VDTs)
_____Desk Work
_____Drafting
_____Driving
_____Biking
_____Motorcycles
_____Fishing/Sailing
_____Reading
_____Sewing/Needlepoint
_____Snow Skiing
_____Swimming

What type of vision correction have you had?

_____None
_____Glasses full time
_____Glasses for distance
_____Glasses for reading
_____Contacts
_____Soft
_____Disposable
_____Rigid Gas Permeable
_____Vision Therapy
_____Patching
_____Exercises

Do you have any questions regarding:

_____Contact Lenses
_____Laser Vision Correction
_____Extra Thin Lenses
_____No Line Bifocals
_____Computer Glasses
_____Sports Goggles
_____Anti-Scratch Coatings
_____Anti-Reflective Coatings
_____Impact Resistant Lenses

How will you settle your account: ___Cash ___Check ___Visa/MC/Discover

Insurance Information:

While we will assist you with insurance billing, you are ultimately responsible for all charges incurred regardless of any third party coverage you may have.

(please continue on the back side)

Vision Insurance_____ Major Medical _____
Patient's ID #_____Patient's ID # _____
If the insured is *other than the patient*, please complete the following *for the policy holder*:
Name_____ Birth _____/_____/_____ Soc. Sec._____
Employer_____ Patient's relation to insured: ___child ___spouse ___other

Review of Systems, Personal, Family, and Social History

This review covers all of the major organ systems, and while they may have nothing to do with your reason for today's examination, doctors of optometry are trained to consider the ocular interactions with these organ systems and to evaluate the effect of any treatment plan on these other systems. The personal, family and social history is intended to explore genetic predisposition, habits or behaviors that may have an impact on today's examination findings. Have you ever had any problems in the following:

You Personally:			Any medications for this? (list)	Family		Relation
Eyes	Y	N		Y	N	
Cataracts	☐	☐	_____	☐	☐	_____
Glaucoma	☐	☐	_____	☐	☐	_____
Macular Degeneration	☐	☐	_____	☐	☐	_____
Retina Detachment	☐	☐	_____	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____	☐	☐	_____
Strabismus (eye turn)	☐	☐	_____	☐	☐	_____
Color Vision Problem	☐	☐	_____	☐	☐	_____
Injury or Surgery	☐	☐	_____			
Other	☐	☐	_____	☐	☐	_____
Ears, Nose, Throat						
Allergies	☐	☐	_____	☐	☐	_____
Sinus Congestion	☐	☐	_____	☐	☐	_____
Chronic Cough	☐	☐	_____	☐	☐	_____
Cardiovascular						
High Blood Pressure	☐	☐	_____	☐	☐	_____
Other	☐	☐	_____	☐	☐	_____
Endocrine						
Diabetes	☐	☐	_____	☐	☐	_____
Thyroid	☐	☐	_____	☐	☐	_____
Hepatitis	☐	☐	_____			
Hormone Replacement	☐	☐	_____			
Immunologic						
HIV or AIDS	☐	☐	_____			
Lupus	☐	☐	_____	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____	☐	☐	_____
Respiratory	☐	☐	_____	☐	☐	_____
Gastrointestinal	☐	☐	_____	☐	☐	_____
Genitourinary, Kidney	☐	☐	_____	☐	☐	_____
Musculoskeletal/arthritis	☐	☐	_____	☐	☐	_____
Skin (acne, keloids etc)	☐	☐	_____	☐	☐	_____
Neurologic (MS, MG etc)	☐	☐	_____	☐	☐	_____
Migraine	☐	☐	_____	☐	☐	_____
Blood/Lymphatic	☐	☐	_____	☐	☐	_____
High Cholesterol	☐	☐	_____	☐	☐	_____
Anemia	☐	☐	_____	☐	☐	_____
Psychiatric						
Anxiety, Depression	☐	☐	_____			
Any Medication Allergy	☐	☐	_____			
Any Other Medications	☐	☐	_____			
Any Other Surgeries	☐	☐	_____			

Other Constitutional Health Symptoms or Issues?_____
Do you use: Tobacco Y N _____packs per day / week; Alcohol Y N ____drinks per day / week
Other substances Y N describe_____

This health history is correct to the best of my knowledge. Signed:_____date_____
Reviewed: