EYE ASSOCIATES NORTHWEST

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Marital Status: _____ Height: _____ Weight: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Race: ❍ American Indian ❍ Asian ❍ African American ❍ Native Hawaiian ❍ Other _____ ❍ Unknown ❍ White

Ethnicity: ❍ Hispanic ❍ Non-Hispanic ❍ Unknown Preferred Language: _____

How did you hear about us? ❍ Physician Referral: _____ ❍ Internet: _____

❍ Insurance: _____ ❍ Other: _____

Is your visit today injury related? ❍ No ❍ Yes Date of Injury: _____ Place: ❍ Home ❍ School ❍ Work ❍ Other

Claim # (if applicable): _____

Health Information

What is the main reason for your visit today? _____

Last Eye Exam: _____ Provider: _____

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Occupation (if retired, list occupation prior to retirement): _____

Computer Use: _____ hours per day

Do you wear glasses? ❍ No ❍ Yes

Do you wear contacts? ❍ No ❍ Yes, brand: _____ How often do you change the lenses? _____

Do you use lubricating eye drops? ❍ No ❍ Yes, frequency: _____

Last Physical Exam: _____ Provider: _____

Preferred Pharmacy: _____ City: _____ Phone or Fax: _____

Please complete both sides.

Health Information (cont.)

Please check the appropriate box to indicate whether you now have, or have ever had, any of the following:

- ❍ Diabetes
- ❍ High blood pressure
- ❍ Irregular heartbeat
- ❍ Stroke
- ❍ Cancer
- ❍ Hay Fever/Seasonal
- ❍ Rosacea
- ❍ Thyroid
- ❍ Arthritis
- ❍ Hepatitis
- ❍ HIV
- ❍ Glaucoma
- ❍ Gout
- ❍ Macular degeneration
- ❍ Singles/Zoster
- ❍ MRSA
- ❍ Tuberculosis
- ❍ Auto-immune disease
- ❍ Bleeding abnormalities
- ❍ Sinus problems
- ❍ Hearing loss
- ❍ Other: _____

Please check the appropriate box for **any current symptoms:**

- ❍ Weight loss/Gain
- ❍ Fatigue
- ❍ Hearing loss
- ❍ Sinus problems
- ❍ Shortness of breath
- ❍ Wheezing
- ❍ Chest pain
- ❍ Irregular heartbeat
- ❍ Abdominal pain
- ❍ Diarrhea/vomiting
- ❍ Urinary pain
- ❍ Blood in urine
- ❍ Excessive
- ❍ Numbness
- ❍ Weakness
- ❍ Headaches
- ❍ Depression/anxiety
- ❍ Rashes
- ❍ Excessively dry skin
- ❍ Muscle aches
- ❍ Joint pain
- ❍ Environmental
- ❍ Other: _____

If you have diabetes, please check: ❍ Type 1 ❍ Type 2 Onset Year: _____ Last HgA1c: _____ Last Blood Sugar: _____
Endocrinologist: _____

Hospitalizations and/or Previous Surgery:
_____

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_____

Do any of your relatives have: ❍ Glaucoma ❍ Retinal Detachment ❍ Macular Degeneration ❍ Diabetes ❍ Blindness ❍ Cataracts ❍ N/A, Adopted

If yes, please list family member(s):

_____

Medications	Dosage (mg)	Frequency

Medication Allergies
❍ Latex ❍ No known allergies

Tobacco Use: ❍ Smoking ❍ Chewing ❍ Never ❍ Former: (____ yr quit) ❍ Current: (____ # of yrs) (____ # per day)

Have you had an injury from a fall in the last year OR have you had more than 2 falls during the past year? ❍ No ❍ Yes

Do you feel lightheaded or unsteady when you stand up or walk? ❍ No ❍ Yes

Do you use a wheelchair? ❍ No ❍ Yes If yes, can you transfer to another chair unassisted? ❍ No ❍ Yes

Patient Printed Name _____ Signature _____

Date _____