La Pine Eyecare Clinic History Form

Patient First Name: _____ M.I.:____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Sex: M F

SS# _____-____-_____ Ethnicity (optional): _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Check box if texting ok **[ ]** Email: _____

Occupation: _____ Employer: _____

Hobbies: _____ Reason for Visit: _____

Guarantor/Parent First Name: _____ M.I.:__ Last Name: _____

If different then Patient

Relationship to Patient: _____ SS# _____

Guarantor/Parent date of Birth: _____ Phone: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Insurance Co: _____ Ins. ID#_____ Group #_____

Name of whom insurance is under: _____ DOB: _____ SS#_____

Do you or your related family members have any of the following conditions?

	YOURSELF		FAMILY	
	YES	NO	YES	NO
Lazy Eye	[ ]	[ ]	[ ]	[ ]
Eye Crossing	[ ]	[ ]	[ ]	[ ]
Cataract	[ ]	[ ]	[ ]	[ ]
Glaucoma	[ ]	[ ]	[ ]	[ ]
Macular Degeneration	[ ]	[ ]	[ ]	[ ]
Reduced Vision	[ ]	[ ]	[ ]	[ ]
Eye Pain	[ ]	[ ]	[ ]	[ ]
Double Vision	[ ]	[ ]	[ ]	[ ]
Eye Injury	[ ]	[ ]	[ ]	[ ]
Flashers/ Floaters	[ ]	[ ]	[ ]	[ ]
Retinal Detachment	[ ]	[ ]	[ ]	[ ]

If you are new to our Eye Clinic, how did you find out about us?

- Medical doctor ? Y N
- Family Member? Y N
- Friend? Y N
- Phone Book? Y N
- Advertisement? Y N
- Internet? Y N
- Other?

_____

Do of the following problems or conditions apply to you?

Multiple Sclerosis	[ ]	Skin Disease	[ ]	Cancer	[ ]
High Blood Pressure	[ ]	G.I. Disease	[ ]	Arthritis	[ ]
Diabetes	[ ]	Kidney Stones	[ ]	Psychiatric	[ ]
Weight Loss	[ ]	Excessive Thirst	[ ]	Chest Pain	[ ]
Sinus Disease	[ ]	Thyroid Disease	[ ]	Easy Bleeding	[ ]
Wheezing/Asthma	[ ]	High Cholesterol	[ ]		

(OVER- NEXT PAGE)

Do you regularly use tobacco? _____ Alcohol? _____
Current Medications: _____
_____
_____
_____
Allergies **to Medications**: _____ Seasonal Allergies: _____

Eye Surgery History: _____

Last Medical Exam: _____ Current Medical Doctor: _____

Last Eye Exam: _____ Last Eye Doctor: _____

Have you ever worn Contact Lenses? _____ If so, what type? _____
Are you interested in Contact lenses? _____

Have you ever worn glasses? _____

Do you use computers? (How often): _____

Do you use sunglasses? (How often): _____

Informed Consent for Dilated Eye Examination:

Medical research indicates that many people need to have their eyes dilated to rule out eye diseases that may cause loss of sight or worse. The dilated fundus examination is recommended for all patients who are new to the practice, those with diabetes, high blood pressure, lupus, symptoms of flashes or floaters, history of retinal problems, highly near-sighted, history of cancer, unexplained headaches, unexplained visual loss, and history of head trauma within the last five years, or at your doctor's discretion.

The drops that are used to dilate your pupils require about 20 minutes to take effect and will keep your pupils dilated for 2 to 4 hours. However, your near vision will improve in 1 to 2 hours. The dilation will cause your vision to be temporarily blurry. Also, your eyes will be sensitive to sunlight, possibly making driving home and continuing your day's activities somewhat difficult, even with sunglasses. Therefore, if necessary, we can reschedule your dilation for a more convenient time.

Side effects from the drops rarely occur, but if you should experience any pain in/around your eyes, hazy vision, haloes around lights, or a sick feeling, please contact your eye doctor as soon as possible.

Please check one:

____ I **want** to have the dilation today.

____ I **do NOT want** to have the dilation today, even though my doctor has advised the procedure as a part of my comprehensive health examination.

Patient signature: _____**Date**: _____
Signing above states all your information is correct to the best of your knowledge.

(OVER- NEXT PAGE)