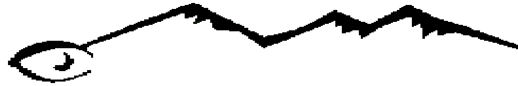

La Pine Eyecare Clinic History Form

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 YES	YOURSELF NO	FAMILY YES	FAMILY 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.

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