WELCOME TO EUGENE VISION CARE

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INSURANCE INFORMATION TO RECEPTIONIST

Date _____

Patient's Full Legal Name _____

DOB _____/_____/_____ Last Four Digits of SSN#_____

Address _____

City _____ State_____ Zip _____

Home Phone_____

Cell Phone _____

Email _____

Employer _____ Occupation _____

Last PCP Visit ____/_____/_____Primary Doctor_____

Last Eye Exam _____/_____/_____

Previous Eye Dr. _____

Vision Insurance Plan_____

Group _____ Policy Number _____

Insured Name _____ Insured DOB ___/___/___

Last Four Digits of SSN#_____

Medical Insurance Plan_____

Group _____ Policy Number _____

Insured Name _____ Insured DOB ___/___/___

Last Four Digits of SSN#_____

Do you wear glasses? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in refractive surgery? ❑ Yes ❑ No

Do you perform fine or close-up work? ❑ Yes ❑ No

Do experience flashes of light? ❑ Yes ❑ No

If yes when? _____

Do you have double vision? ❑ Yes ❑ No

If yes, when?_____

What is the main reason for your visit today? _____

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	❑	❑
Cardiovascular		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Stroke	❑	❑
Vascular Disease	❑	❑
Ears/Nose/Mouth/Throat		
Allergies	❑	❑
Sinus Congestion	❑	❑
Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Mouth/Throat	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑

	Yes	No
Gastrointestinal		
Constipation	❑	❑
Crohn's Disease	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Ulcer / Reflux	❑	❑
Genito-Urinary		
Bladder / Genital / Kidney	❑	❑
Herpes Simplex	❑	❑
Prostate	❑	❑
Musculoskeletal		
Joint / Muscle Pain	❑	❑
Osteo Arthritis	❑	❑
Rheumatoid	❑	❑
Integumentary (skin)		
Skin Cancer	❑	❑
Skin Disease	❑	❑
Herpes Zoster/Shingles	❑	❑
Gout	❑	❑

	Yes	No
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Multiple Sclerosis	❑	❑
Seizures	❑	❑
Psychiatric		
Anxiety / Depression	❑	❑
Endocrine		
Diabetes Type I	❑	❑
Diabetes Type II	❑	❑
Thyroid/Other Glands	❑	❑
Lymphatic – Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic / Immunologic		
Eczema	❑	❑
Hives	❑	❑
Lupus	❑	❑
Organ transplant	❑	❑
HIV	❑	❑

Office Use:

NP EP IN NI EG CL OV

Please Complete Both Sides of the Form OVER →

Ocular History

(mark yes or no to each question)

Age-related macular degeneration	❑ Yes	❑ No	Injury to the eye region	❑ Yes	❑ No
Amblyopia (Lazy eye)	❑ Yes	❑ No	Keratoconus	❑ Yes	❑ No
Blindness-one eye	❑ Yes	❑ No	Retinopathy	❑ Yes	❑ No
Bindness-both eyes	❑ Yes	❑ No	Strabismus (Crossed eyes)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Tear film insufficiency (dry eyes)	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Other _____		
History of refractive surgery	❑ Yes	❑ No	_____		

Family Health History ❑ Unknown

(mark yes or no to each entry. If yes then circle which family member. F=Father, M=Mother, B=Brother, S=Sister, A=Aunt, U=Uncle, G=Grandparent)

Amblyopia (Lazy eye)	❑ Yes	❑ No	F	M	B	S	A	U	G	Strabismus (cross eyes)	❑ Yes	❑ No	F	M	B	S	A	U	G
Blindness and/or vision impairment	❑ Yes	❑ No	F	M	B	S	A	U	G	Arthritis	❑ Yes	❑ No	F	M	B	S	A	U	G
Cataract	❑ Yes	❑ No	F	M	B	S	A	U	G	Cancer	❑ Yes	❑ No	F	M	B	S	A	U	G
Macular Degeneration	❑ Yes	❑ No	F	M	B	S	A	U	G	Diabetes mellitus	❑ Yes	❑ No	F	M	B	S	A	U	G
Glaucoma	❑ Yes	❑ No	F	M	B	S	A	U	G	Hypertension (high blood pressure)	❑ Yes	❑ No	F	M	B	S	A	U	G
Retinal disorder	❑ Yes	❑ No	F	M	B	S	A	U	G	Cardiovascular disease	❑ Yes	❑ No	F	M	B	S	A	U	G
										Stroke	❑ Yes	❑ No	F	M	B	S	A	U	G

Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

_____

_____

_____

_____

❑ No Medications

Allergies

List any allergies you may have and reaction.

_____

_____

_____

_____

❑ No Medication Allergies ❑ No Other Allergies

Visual Field Testing

Visual field testing is a tool used by your eye care provider to detect defects in your visual field. These defects can be caused by a number of medical conditions that can affect your eyes or the pathway from your eyes to your brain. These conditions include but are not limited to:

- Diabetes
- High Blood Pressure
- Stroke
- Glaucoma

This visual field screening is NOT typically covered by insurance but is highly recommended by your doctor. Please indicate if you would like this visual field screening test.

❑ Yes , I would like the visual field screening test completed and agree to pay the associated fee. Fee: $20

❑ I do NOT want to do the visual field screening test at this visit.

Patient/Guardian Signature:_____ Date:_____