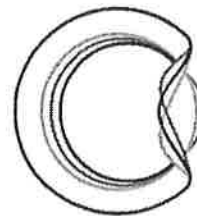


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**COLUMBIA RIVER**  
 EYE CENTER

**PATIENT INFORMATION**

Acct. #:

Last Name		First Name		Middle Initial
Address		City	State	Zip
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security#	Primary Care Physician	
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Spouse's Name and Date of Birth		Preferred Pharmacy	
Home Phone	Work Phone	Cell Phone	E-mail address	
Local emergency contact, other than parent or spouse		Phone #	Relationship to Patient	

**FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT IF OTHER THAN SELF**

Name and Date of Birth (subscriber of Insurance Policy) \_\_\_\_\_

Who is the responsible party?  Mother  Father  Both  Other \_\_\_\_\_

Resp party's full name _____
Address _____
Date of Birth _____
Social Security # _____
Work Phone _____

Insurance name _____
Billing address: _____
Policy # _____
Group # _____
_____

Referred by: <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Optometrist <input type="checkbox"/> Doctor
Name of referring doctor or person: _____

**INSURANCE AUTHORIZATION AND INFORMATION**

I hereby authorize The Columbia River Eye Center to furnish information to insurance carriers concerning any illness and treatment, and fully assign payment directly to the doctor for services rendered. All the above information is true to the best of my knowledge. I understand I am liable for any and all charges insurance does not pay. I also agree to pay any collection and/or attorney fees that should arise from nonpayment.

Signature: (patient or guardian) \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_

List all **MEDICATIONS** you currently take:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any medication **ALLERGIES** you have:

\_\_\_\_\_

\_\_\_\_\_

List all **MAJOR ILLNESSES** (diabetes, high blood pressure, etc.) or injuries (concussion, etc.):

\_\_\_\_\_

\_\_\_\_\_

List all previous **SURGERIES** (eye surgeries included):

\_\_\_\_\_

\_\_\_\_\_

Circle any problems you are *currently* experiencing with your **EYES**

### VISION

Glare  
Blurred  
Double

Distorted  
Fluctuating  
Loss of vision

### OTHER

Glaucoma  
Macular Degeneration

### DISCOMFORT

Dry  
Itching  
Sandy / Gritty

Watery  
Redness  
Discharge

Cataracts  
Eye Lid Abnormalities

### SOCIAL HISTORY

Current occupation: \_\_\_\_\_

Do you drive?  YES  NO

Do you have visual difficulty when driving?  YES  NO

Do you have problems with night vision?  YES  NO

Have you ever tried to wear contact lenses?  YES  NO

Do you currently wear contact lenses?  YES  NO

If YES, how long have you worn contact lenses? \_\_\_\_\_

Do you currently wear glasses?  YES  NO

If YES, how long have you had the current prescription? \_\_\_\_\_

Do you drink alcohol?  YES  NO if YES: occasional 1/day 2-3/day 4+/day

Do you smoke?  YES  NO if YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion?  YES  NO

Do you exercise regularly?  YES  NO

Check any conditions which apply to you

**GENERAL HEALTH**

- Fever
- Weight loss \_\_\_\_\_ lbs.
- Weight gain \_\_\_\_\_ lbs.
- Other \_\_\_\_\_

**GASTROINTESTINAL**

- Ulcer
- Reflux
- Irritable Bowel
- Ulcerative Colitis / Crohn's
- Other \_\_\_\_\_

**NEUROLOGICAL**

- Stroke
- Multiple Sclerosis
- Parkinson's
- Other \_\_\_\_\_

**EARS / NOSE / THROAT**

- Sinus infection
- Ear infection
- Chronic cough
- Dry mouth
- Other \_\_\_\_\_

**CANCER**

- Breast
- Prostate
- Lung
- Colon
- Other \_\_\_\_\_

**PSYCHIATRIC**

- Anxiety
- Depression
- Insomnia
- Other \_\_\_\_\_

**CARDIOVASCULAR**

*Disease*

- High blood pressure
- High cholesterol
- Heart attacks
- Other \_\_\_\_\_

**URINARY TRACT**

- Kidney problems
- Other \_\_\_\_\_

**ENDOCRINE**

- Diabetes
- Thyroid
- Other \_\_\_\_\_

*Surgery*

- Angioplasty
- Bypass
- Valve replacement
- Carotid Artery
- Other \_\_\_\_\_

**BLOOD / LYMPH**

- Anemia
- Hepatitis
- HIV
- Other \_\_\_\_\_

**MUSCLES / BONES / JOINTS**

- Osteoarthritis
- Rheumatoid Arthritis
- Osteoporosis
- Other \_\_\_\_\_

**RESPIRATORY**

- COPD
- Asthma
- Emphysema
- TB
- Other \_\_\_\_\_

**SKIN**

- Acne
- Psoriasis
- Skin cancer
- Rosacea
- Other \_\_\_\_\_

**ALLERGIC / IMMUNOLOGIC**

- Hay fever
- Lupus
- Sjogrens
- Other \_\_\_\_\_

**FAMILY HISTORY** M = Mother F = Father S = Sibling GP = GrandParent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Strabismus / Amblyopia / Lazy eye			
Migraines			
Diabetes			
Heart disease or high blood pressure			
Stroke			
Cancer			
Other			