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COLUMBIA RIVER
EYE CENTER

## PATIENT INFORMATION

**Acct. #:** _____

| | |
|---|---|
| Last Name | First Name Middle Initial |
| Address | City State Zip |
| Sex ☐ Male ☐ Female Date of Birth Social Security# | Primary Care Physician |
| Marital Status ☐ S ☐ M ☐ D ☐ 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: ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Optometrist ☐ 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

**DISCOMFORT**

Dry
Itching
Sandy / Gritty
Watery
Redness
Discharge

**OTHER**

Glaucoma
Macular Degeneration
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 ½ 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 _____

***Surgery***
- ☐ Angioplasty
- ☐ Bypass
- ☐ Valve replacement
- ☐ Carotid Artery

Other _____

**URINARY TRACT**
- ☐ Kidney problems

Other _____

**ENDOCRINE**
- ☐ Diabetes
- ☐ Thyroid

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 | | | |