WELCOME TO EUGENE VISION CARE

PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE INFORMATION TO RECEPTIONIST

Date ______________________________

Patient's Full Legal Name ______________________________

DOB ______/_______/_______ Single/Married/Widowed/Divorced

Address ____

City ________________________ State_______ Zip __________

Phone ____

Email ____

Employer _____________________ Occupation ____________

Last PCP Visit ____/_____/_____ Primary Doctor_____________

Last Eye Exam ______/______/______

Previous Eye Dr. _____________________________

Vision Insurance Plan________________________________

Group _______________ ID Number _______________

Insured Name ________________ Insured DOB ___/___/___

Last Four Digits of SSN#______

Medical Insurance Plan______________________

Group _______________ ID Number _______________

Insured Name ________________ Insured DOB ___/___/___

Last Four Digits of SSN#______

Question	Yes	No
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? ________________________________

Question	Yes	No
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?

Condition	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	❏	❏
Gastrointestinal		
Crohn's Disease	❏	❏
Hepatitis A	❏	❏
Hepatitis B	❏	❏
Hepatitis C	❏	❏
Ulcer / Reflux	❏	❏
IBS	❏	❏
Genito-Urinary		
Bladder / Genital / Kidney	❏	❏
Herpes Simplex	❏	❏
Prostate	❏	❏
Musculoskeletal		
Joint / Muscle Pain	❏	❏
Osteo Arthritis	❏	❏
Rheumatoid	❏	❏
Gout	❏	❏
Integumentary (skin)		
Eczema	❏	❏
Skin Cancer	❏	❏
Psoriasis	❏	❏
Herpes Zoster/Shingles	❏	❏
Neurological		
Headaches	❏	❏
Migraines	❏	❏
Multiple Sclerosis	❏	❏
Seizures	❏	❏
Psychiatric		
Anxiety / Depression	❏	❏
Endocrine		
Diabetes Type I	❏	❏
Diabetes Type II	❏	❏
Thyroid/Other Glands	❏	❏
Lymphatic – Hematologic		
Anemia	❏	❏
Bleeding Problems	❏	❏
Immunologic		
Cancer	❏	❏
Grave's Disease	❏	❏
Hives	❏	❏
Lupus	❏	❏
Organ transplant	❏	❏
HIV	❏	❏

Office Use:

NP EP IN NI EG CL OV

Please turn over and complete backside of form.

Ocular History

(mark yes or no to each question)

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

Other ____

____

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)

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

Tobacco Use/Smoking History

❑ Cigargette smoker
❑ Cannabis smoker
❑ Vape
❑ Smokeless Tobacco
❑ Light tobacco smoker
❑ Former smoker
❑ NEVER Smoker

Medications

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

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❑ No Medications

Allergies

List any allergies you may have and reaction.

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❑ No Medication Allergies ❑ No Other Allergies

Patient/Guardian Signature:__________________________________ Date:______________