PATIENT'S INFORMATION

NAME: _____
ADDRESS:_____
CITY: _____ STATE _____ ZIP _____
DATE OF BIRTH: _____ / _____ / _____
OCCUPATION:_____
CELL PHONE #: _____-_____-_____
PHONE (OTHER):_____-_____-_____
EMAIL:_____@_____.COM

REASON FOR VISIT: (CHECK ALL THAT APPLY)

- ☐ GENERAL EYE HEALTH EXAM
- ☐ ROUTINE VISION EVALUATION
- ☐ MEDICAL EMERGENCY EXAM
- ☐ CONTACT LENS EVALUATION
- ☐ MYOPIA CONTROL
- ☐ LASIK CONSULTATION
- ☐ OTHER_____

INSURANCE INFORMATION

MEDICAL INSURANCE _____
SUBSCRIBER NAME _____
SUBSCRIBER ID# _____
SUBSCRIBER SSN# _____-_____-_____
SUBSCRIBER BIRTHDAY _____/_____/_____

VISION INSURANCE _____
SUBSCRIBER NAME _____
SUBSCRIBER ID# _____
SUBSCRIBER SSN# _____-_____-_____
SUBSCRIBER BIRTHDAY _____/_____/_____

PATIENTS ARE RESPONSIBLE FOR UNDERSTANDING THEIR COVERAGES.

****0% FINANCING ON ALL ORDERS $250+ WITH CARE CREDIT SERVICES****

PATIENT'S EYE HISTORY

LAST EYE EXAM:_____
DOCTOR:_____

DO YOU WEAR GLASSES? ☐ YES ☐ NO

- ☐ ALL THE TIME
- ☐ READING ONLY
- ☐ DISTANCE ONLY

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO
BRAND? _____
REPLACED ☐ DAILY
☐ 1-2 WEEKS
☐ MONTHLY
☐ GAS PERMEABLE/HARD

☐ CHECK HERE IF YOU ARE INTERESTED IN ORTHOKERATOLOGY - (LASIK ALTERNATIVE FOR ALL AGES.)

ARE YOU **CURRENTLY** EXPERIENCING ANY OF THESE SYMPTOMS?

- ☐ BLURRY VISION (FAR, COMPUTER, OR CLOSE)
- ☐ HEADACHES (DAILY, WEEKLY, OTHER)
- ☐ RED EYES (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ BURNING (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ ITCHING (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ TEARING (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ DISCHARGE (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ DOUBLE VISION (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ FLASHES OF LIGHT (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ SEEING SPOTS (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ LIGHT SENSITIVITY (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ NIGHT PROBLEMS (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ TOTAL BLINDNESS (STARTED _____DAYS/WKS/MONTHS/YRS)
- ☐ OTHER_____

HAVE YOU **EVER** BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING?

- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ MACULAR DEGENERATION
- ☐ DIABETIC EYE PROBLEMS
- ☐ EYE INJURY
- ☐ RETINAL DETACHMENT
- ☐ BLINDNESS
- ☐ EYE TURN/ STRABISMUS
- ☐ LAZY EYE/AMBLYOPIA
- ☐ DRY EYE
- ☐ OTHER_____
  _____
- ☐ EYE SURGERY FOR:
  _____
  _____
  _____
  _____

MEDICAL DRY EYE QUESTIONAIRE

	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
SENSITIVITY TO LIGHTS	4	3	2	1	0
SANDY/GRITTY FEELING	4	3	2	1	0
PAIN/SORENESS	4	3	2	1	0
BLURRED VISION	4	3	2	1	0
MUCUS/CRUSTY EYES	4	3	2	1	0

MEDICAL DRY EYE ACTIVITIES

WHAT ACTIVITIES ARE AFFECTED BY YOUR DRY EYES?

- ☐ CANNOT READ FOR LONG PERIODS OF TIME
- ☐ VISION FLUCTUATES WHILE READING/COMPUTER
- ☐ EYES ARE WATERY/ITCHY WHEN OUTSIDE
- ☐ EYES FEEL HEAVY ON THE COMPUTER
- ☐ CONSTANTLY RUBBING EYES
- ☐ EYES ARE RED AFTER COMPUTER USE
- ☐ EYES ARE HARD TO OPEN IN THE MORNING
- ☐ CONTACT LENSES ARE DRY OR CANNOT USE

CONTINUE →

PRIMARY CARE PHYSICIAN _____ PHARMACY NAME:_____
TELEPHONE #_____ TELEPHONE #_____
LAST PHYSICAL EXAM _____

DISEASE – CHECK ALL THAT APPLY	**MEDICATION(S)-PLEASE LIST** **CAN GREENLAKE EYE CARE ACCESS YOUR MEDICATIONS FROM AN ONLINE PHARMACY?** **(CIRCLE ONE) YES NO**
☐ DIABETES (PRE--TYPE 1--TYPE 2)	
☐ HIGHT BLOOD PRESSURE	
☐ HIGH CHOLESTEROL	
☐ HEART DISEASE	
☐ STROKE	
☐ CANCER – (PLEASE SPECIFY)	
☐ THYROID DISEASE	
☐ ASTHMA	
☐ COPD/BREATHING DISORDERS	
☐ RHEUMATOID ARTHRITIS	
☐ DEPRESSION	
☐ ANXIETY	
☐ ATTENTION DEFICIT DISORDER(ADHD)	
☐ AUTISM	
☐ LUPUS	
☐ OTHER:	
☐ OTHER:	
☐ OTHER:	
☐ CURRENTLY PREGNANT: YES/NO	

☐ ***NO SIGNIFICANT MEDICAL HISTORY***

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING CONDITIONS?
PLEASE LIST THE AFFECTED FAMILY MEMBERS.

	FATHER	MOTHER	BROTHER	SISTER
MACULAR DEGENERATION				
BLINDNESS				
GLAUCOMA				
EYE TURN/STRABISMUS				
LAZY EYE/AMBLYOPIA				
MYOPIC DEGENERATION (HIGH NEARSIGHTED)				
CANCER				
DIABETES				
HIGH BLOOD PRESSURE				
HEART DISEASE				

☐ ***NO REMARKABLE FAMILY HISTORY***

EYE DROPS	***MEDICATION ALLERGIES***	***SOCIAL HISTORY***
1._____ 2._____ 3._____ 4._____ ☐ ***I DO NOT USE EYEDROPS***	1._____ 2._____ 3._____ 4._____ ☐ ***NO KNOWN DRUG ALLERGIES***	ALCOHOLIC BEVERAGES ☐ NONE ☐ RARELY ☐ SOCIALLY ☐ DAILY SMOKING ☐ NONE – NO PRIOR HISTORY ☐ NONE – PREVIOUS SMOKER ☐ 1 PACK/DAY ☐ 2+ PACKS/DAY