

WELCOME TO BEAVERTON OPTOMETRIC GROUP!

Please complete/update the following confidential information. Let us know if you would like help in completing the form.

DEMOGRAPHICS

Last Name: _____ First Name: _____ M.I.: _____
Sex: M _____ F _____ Date of Birth: _____ Single Married Domestic Partner Widowed
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
Email: _____ Occupation: _____ Employer: _____
Emergency Contact: _____ Relation: _____ Phone: () _____

MEDICAL INFORMATION

Last Eye Exam, if not here: _____ Eye Doctor/Office: _____
Last Medical Exam: _____ Family Practitioner: _____
Do you wear Glasses? No Yes If yes, how old is your present pair of lenses? _____
Do you wear Contact lenses? No Yes If yes, how old is your present pair of lenses? _____
Type of Contact Lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No
If you drive, do you have visual difficulty when driving? No Yes- Please explain: _____

Have you ever been diagnosed with:

Glaucoma Cataracts Macular Degeneration Dry Eyes Keratoconus
 Retinal detachment/disease Eye infections, chronic Crossed eyes Lazy eye
Any other Eye Conditions/Problems? No Yes What kind? _____
Have you had any Eye Operations? No Yes Type: _____ Date: _____
Have you had any Eye Injuries? No Yes Type: _____ Date: _____

Medications

Do you have any Medication/Food Allergies? No Yes, Type & Reaction? _____

Do you take ANY Medications? No Yes - Please list all Prescription, Non-prescription, routine use & as-needed use. Include oral contraceptives, Vitamins/Herbals: _____

Past Medical History/Habits

List major injuries, surgeries and/or hospitalizations: _____

You may discuss the following personal information with the doctor if you prefer:

How much tobacco product do you use? None Type/amount/years: _____
How much Alcohol do you drink? None Type/amount/years: _____
How often do you use illicit drugs? None Type/amount/years: _____

Hobbies/Sports:

Do you currently, or have you ever had any chronic/serious problems in the following areas:

	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>
EYES			SKIN PROBLEMS:	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	EARS, NOSE, MOUTH, THROAT		
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/HayFever	<input type="checkbox"/>	<input type="checkbox"/>
Blurred or Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	Sinus/Cold Symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR		
Mucous/Discharge	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular problems	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Sandy/Gritty/Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Crohns/Inflammatory/Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, Chronic	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder/Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES		
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis/Lupus	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			AUTOIMMUNE DISORDERS:	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular/Movement Disorders	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNOLOGIC/INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			Hepatitis / HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION/MENTAL HEALTH	<input type="checkbox"/>	<input type="checkbox"/>
Hypo or Hyper-Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR NURSING?	<input type="checkbox"/>	<input type="checkbox"/>
Other Gland disorders:					

If you answered YES to any of the above or have a condition not listed, please explain:

FAMILY HISTORY Please note parents, grandparents, siblings, children; living or deceased, for the following:

	No	YES	RELATION		No	YES	RELATION
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid Arthritis, Lupus, Autoimmune	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

How did you select our office?

Referred by: _____
 Family has been in _____
 Previous exam here
 Insurance Plan
 Phone book
 Internet search
 Health Fair
 Other _____

Would you like more information on:

<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Glasses	<input type="checkbox"/> Computer vision	<input type="checkbox"/> Floaters
<input type="checkbox"/> Orthokeratology (corrective therapy)	<input type="checkbox"/> Progressives	<input type="checkbox"/> Astigmatism	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Sunglasses	<input type="checkbox"/> Laser Surgery	<input type="checkbox"/> Cataracts
	<input type="checkbox"/> Sports glasses	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Glaucoma

SIGNED: _____ Date: _____
 Signature of responsible party (parent/guardian if < 18 y.o.)