7367 SW Bridgeport Rd	2383 NW Thurman St	4441 SE Woodstock Blvd	3333 SE Belmont St
Portland, OR 97224	Portland, OR 97210	Portland, OR 97206	Portland, OR 97214
503-372-5013	503-227-0022	503-775-4550	503-719-4792

Name ______________________________ Date ____/____/____ DOB ____/____/____

Address ______________________________ Phone ______-______-________

Email ______________________________ Occupation ____________________

How did you hear about us? Insurance PCP Google Yelp Drive / Walk by Other ____________________

Primary Care Physician / Office location: ______________________________

Reason for today's visit? ____________
____
____
____

How old are your glasses?____________

Do you need a new contact lens prescription? ☐yes ☐no

What brand of contacts do you wear?
____

How old is your current pair of contacts?
____

Are you satisfied with the vision and comfort of your contacts? If not, why?
____
____

Do you have questions about Laser Vision Correction? ☐ yes ☐ no

Please check the conditions your eyes are bothered by:

- ☐ Headaches
- ☐ Motion sickness while reading in a moving vehicle
- ☐ 3D Movies
- ☐ Night Driving
- ☐ Losing place when reading
- ☐ Excessive glare
- ☐ Double Vision
- ☐ Excessive light sensitivity
- ☐ Dry/burning eyes
- ☐ Itchy eyes due to allergies
- ☐ Floaters in vision
- ☐ Flashes of light in vision

____

Office Use Only:
Presenting RX:
OD:
OS:
PP Coding Y N

Personal Ocular History

Please check all conditions that apply:

☐ Cataracts ☐ Dry Eyes ☐ Eye Turn ☐ Glaucoma ☐ Macular Degeneration

☐ Eye Injury ____________________ Eye: R L When? ____________

☐ Eye Surgery ____________________ Eye: R L When? ____________

☐ Other Conditions ______________________________

Personal Medical History

Please check all conditions that apply:

Allergic/Immunologic
- ❏ Drug Allergy
- ❏ Environmental Allergy
- ❏ Rheumatoid Arthritis

Endocrine
- ❏ Non-insulin diabetes
- ❏ Insulin-de diabetes
- ❏ Thyroid dysfunction

Hematologic
- ❏ Anemia
- ❏ High cholesterol
- ❏ Leukemia

Respiratory
- ❏ Asthma
- ❏ Bronchitis
- ❏ Cigarette smoker

Cardiovascular
- ❏ Heart Disease
- ❏ High blood pressure
- ❏ Stroke

Gastrointestinal
- ❏ Ulcer
- ❏ Acid reflux

Musculoskeletal
- ❏ Ankylosing Spondylitis
- ❏ Fibromyalgia
- ❏ Osteoarthritis

Skin
- ❏ Eczema
- ❏ Rosacea

Constitutional
- ❏ Cancer
- ❏ Dev. disability

Genitourinary
- ❏ Pregnant
- ❏ Nursing

Neurological
- ❏ Epilepsy
- ❏ Multiple sclerosis
- ❏ Migraine

Other
- ❏ ______________
- ❏ ______________

If checked, please explain: ______________________________
____
____

Please list any medications you are currently taking, including eye drops and over-the-counter medications. ______________________________
____
____

Please list any medication allergies or sensitivities : ____________________
____

Family Medical History

Please check the blood relatives who have the following conditions:

Cataracts	❏ Father	❏ Mother	❏ Other____________
Diabetes	❏ Father	❏ Mother	❏ Other ____________
Glaucoma	❏ Father	❏ Mother	❏ Other ____________
High blood pressure:	❏ Father	❏ Mother	❏ Other ____________
Macular degeneration:	❏ Father	❏ Mother	❏ Other ____________