Christopherson EYE CLINIC

Thank you for choosing our office for your vision care.
In order to provide you with the best care possible, we ask that you answer the questions below.
If you prefer, we will be happy to sit down with you to help you complete this form.
We are here to assist you.

Date:___/____/_____ **Name:**(last) _____(First)_____(M.I.)____ **DOB:**___/____/_____

Nickname/Preferred name:_____ **Preferred Language:** _____**Last 4 of SSN**:_____

Email:_____ **Preferred form of contact:** Phone ☐ Text ☐ Email ☐ Mail ☐

Complete Address:_____

Best Phone #:_____ **2nd Phone:**_____

Emergency Contact - Name:_____**Relationship**:_____**Phone#**_____

Preferred Clinic: _____ **Primary Care Physician:**_____

Insurance: (Medical) _____ (Vision)_____**Preferred Pharmacy:**_____

Reason for today's visit:_____

PLEASE inform the front desk if you have recently started or finished taking PREDNISONE

Please note *family* history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Y	N	?	Relationship to you	Disease/Condition	Y	N	?	Relationship to you
Blindness					Cataract				
Crossed Eyes					Glaucoma				
Macular Degeneration					Retinal Detachment				
Arthritis					Cancer				
Diabetes					High Blood Pressure				
Kidney Disease					Lupus				
Thyroid problems					Other:_____				

Do you use a device with a screen?

(TV, *phone, tablet, computer,, play video games, etc*) Yes☐ No☐ If yes, hours per day? _____

Do you read?(*books,magazines,newspapers,etc*) Yes ☐ No ☐ If yes, hours per day? _____

Are you interested in Lasik? Yes ☐ No ☐ **Is this visit work related? :** Yes ☐ No ☐

Do you wear contact lenses? Yes☐ No☐ if no, are you interested in contacts? Yes☐ No☐

if yes… What type of contacts? Hard ☐ Soft ☐ Daily ☐ Other ☐ Name of brand (*if known*) _____

Are they comfortable? Yes☐ No☐ If no, please describe_____

What Hobbies do you have? _____

<u>*Please complete the other side*</u>

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health

Please provide a list of medications to the front desk to be copied or please list (*including oral contraceptives, aspirin, over the counter medications and vitamins*)._____

Any Allergies:(Medication,seasonal,etc)_____

Do *<u>you</u>* currently, or have you had any problems in the following areas?

	Y	N	?		Y	N	?		Y	N	?
Autoimmunity				Blurred Vision				**Lymphatic/Hematologic**			
Vascular/Cardiovascular				Loss of Vision				Anemia			
Heart Disease/High Cholesterol				Distorted Vision/Halos				Bleeding Problems			
High Blood Pressure				Loss of Side Vision				**Integumentary** *(Skin)*			
Stroke				Fluctuation in Vision				Lupus			
Constitutional*(whole body)*				Poor night vision				**Bones/Joints/Muscles**			
Weight Loss/Gain *(abnormal)*				Double Vision				Muscle Pain/Joint Pain			
Cancer -type_____				Tired Eyes				Rheumatoid Arthritis *(RA)*			
Multiple sclerosis (MS)				Mucous Discharge				**Neurological**			
Ear/Nose/Mouth/Throat				Redness				Headaches			
Allergies/Hay Fever				Sandy or Gritty Feeling				Migraines			
Sinus Congestion				Itching				Seizures			
Endocrine				Burning				Cognitive Issues - type_____			
Thyroid Problems				Foreign Body Sensation				Depression			
Diabetes ***1*** *or* ***2*** *- please circle*				Excess Tearing/Watering				Anxiety			
Eyes				Glare/Light Sensitivity				**Respiratory**			
Macular Degeneration				Eye Pain or Soreness				Asthma			
Cataracts (past or current)				Sties				COPD			
Glaucoma				Dryness				Emphysema			
Retinal Detachment				Flashes/Floaters in Vision				**Pregnant/Nursing**			
Cross Eyed/Strabismus				**Gastrointestinal** *(Gut health)*				Other:			

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Patient Signature:_____Date:_____

Parent/Guardian_____Date:_____