TUALATINEYE ASSOCIATES

Patient Information

Name: Day #:

Address: Home #:

Email: Date of Birth: 2024

Height: _____ Weight: _____ Sex: M F Other

Primary Care Physician / Location _____

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes Please list _____

List any medications you take(including oral contraceptives, asprin, OTC meds & home remedies):

_____ _____ _____ _____

_____ _____ _____ _____

Diabetic:

Last A1C: _____ Date: _____

Glucometry. _____ Date: _____

Do you use tobacco products? ☐ No ☐ Yes If yes, type, amt, how long: _____

Do you use alcohol? ☐ No ☐ Yes If yes, type, amt, how long: _____

Do you use illegal/ish drugs? ☐ No ☐ Yes If yes, type, amt, how long: _____

Have you ever had LASIK, Keratotomy, PRK. Date / Facility: _____

Eye Symptoms

- ☐ Blur
- ☐ Night Blur
- ☐ Double VIsion
- ☐ Blink to Clear Vision
- ☐ Itchiness
- ☐ Burning, Sting
- ☐ Tearing
- ☐ Dryness
- ☐ Sandy / gritty
- ☐ Redness
- ☐ Discharge
- ☐ Pain
- ☐ Light Sensitivity
- ☐ Tired Eyes
- ☐ Squinting
- ☐ Light Flashes
- ☐ Floating spots
- ☐ Eye Strain
- ☐ Dizziness

Personal Medical History

- ☐ Diabetes
- ☐ HB Pressure
- ☐ Heart Disease
- ☐ Melanoma / Cancer
- ☐ Allergy
- ☐ Novocain Allergy
- ☐ Drug Allergies
- ☐ High Cholesterol
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Emphysema
- ☐ Pregnant
- ☐ Arthritis, Lups
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Sarcoidosis
- ☐ Kidney Disease
- ☐ Hepatitis C
- ☐ Shingles
- ☐ Rosacea
- ☐ Thyroid Disease

Family Medical History

- ☐ Diabetes
- ☐ HB Pressure
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness
- ☐ Color Blindness
- ☐ Cancer
- ☐ Arthritis / Lupus
- ☐ Macular Degeneration
- ☐ Crossed Eyes
- ☐ Thyroid Disease
- ☐ Other _____

Computer Use Symptoms

- ☐ Eye Strain
- ☐ Intermittne Blur
- ☐ Focusing trouble
- ☐ Eye Fatigue
- ☐ Dryness
- ☐ Stinging/Burning
- ☐ Double Vision
- ☐ Headache
- ☐ Tense muscles
- ☐ General Fatigue

Personal Ocular History

- ☐ Disease
- ☐ Injury
- ☐ Surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Pink Eye
- ☐ Styes
- ☐ Crossed Eyes
- ☐ AMD
- ☐ Color Deficiency
- ☐ Other Eye Problems
- ☐ _____

Other health Issues not listed

_____

_____

_____

_____

_____

I certify to the best of my knowledge the above information is complete & accurate. If the vision/health plan information is not accurate, or if I am not eligible to receive a vision/health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes to my health condition or vision/health plan coverage in the future.

Patient Signature(or Guardian): _____ **Date:** _____

_____ _____

Doctor's Signature Date