CASCADE EYE M.D.s

*** PLEASE COMPLETE BOTH SIDES OF FORM ***

Place patient sticker here

Today's Date: ________________________

Patient's Name: ____ ☐ Male ☐ Female
Last First Middle

Address ____ Date of birth: ____________________
City ________________________________ State ______ Zip __________ SSN: ______________________
Home phone ( ) ______________ Work phone ( ) ________________ Cell phone ( ) ________________
Employer ____________________________ Occupation __________________________ Marital Status ___________

Emergency contact ____ Phone ( ) ______________________

INSURANCE INFORMATION

- Please present all medical insurance cards at time of check-in for your appointment.
- If you do not have insurance coverage, payment is due on the date of service.
- If you have a work-related injury, you must provide us with the L&I claim number.
- **Routine vision exams are often provided through a vision plan that is separate from your medical plan and may have a different provider network. Please check your routine vision benefit.**

PREFERRED PHARMACY:

______________________________ ______________________________ ( ) __________________
Pharmacy Address/City Phone

DID A HEALTH CARE PROVIDER REFER YOU FOR THIS VISIT? ☐ Yes ☐ No
If yes, name of clinician and clinic: ____

PRIMARY CARE PHYSICIAN ___________________________________ Phone ( ) __________________

LIST YOUR CURRENT MEDICATIONS	MEDICATION ALLERGIES
____	____________________________
____	____________________________
____	____________________________
____	____________________________
____	____________________________
☐ **Check here if you do not currently take any medications**	☐ **Check here if no medication allergies**

INJURY INFORMATION

Is your visit related to an injury? ☐ Yes ☐ No Date of injury: ____________ ☐ Right eye ☐ Left eye ☐ Both
Place of injury: ☐ Home ☐ Work ☐ Other (please specify): ________________
If related to work injury: Employer at time of injury: ____________________________ Phone: ( ) ____________
Has your employer been notified? ☐ Yes ☐ No Has Claim been filed? ☐ Yes ☐ No Claim No. _______________

→PLEASE COMPLETE OTHER SIDE OF FORM →

YOUR PERSONAL OCULAR HISTORY:

☐ Prescription glasses (how old is prescription? ____ years) ☐ Readers (power: ________) ☐ Contact lens wearer
☐ Cataract ☐ Glaucoma ☐ Glaucoma suspect ☐ Diabetic retinopathy
☐ Crossed eye (strabismus) ☐ Patching one eye as a child ☐ Amblyopia ☐ Corneal disorder
☐ Retinal tear or detachment ☐ Macular degeneration ☐ Eye injury ☐ Eyelid disorder
☐ Other: ____
☐ Prior ocular or eyelid surgery(ies): ____ (include which eye and year)

FAMILY OCULAR HISTORY (*patient's biological mother, father, siblings and grandparents*):

☐ Cataract(s) ☐ Glaucoma ☐ Glaucoma suspect
☐ Crossed eye (strabismus) ☐ Macular degeneration ☐ Retinal tear or detachment
☐ Corneal disease ☐ Other: ____

YOUR PERSONAL MEDICAL HISTORY (check all that apply)

☐ Diabetes (year diagnosed ___________ , blood sugars range ____________ , last HbA1C if known _____________)
☐ High cholesterol ☐ High blood pressure ☐ Coronary artery disease ☐ Other heart problems: _______________
☐ Stroke or TIA ☐ Asthma ☐ COPD/emphysema ☐ Arthritis
☐ Thyroid disease ☐ HIV/AIDS ☐ Hay fever/allergies ☐ Eczema/dry skin
☐ Sinus disease ☐ Cancer (please specify): ____
☐ Other medical history: ____
☐ Previous surgeries or hospitalizations (and year): ____
____

SOCIAL HISTORY:

Do you smoke cigarettes (or cigars)? ☐ Yes ☐ No If yes, how many years: _____ How many packs per day: ______
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks a week: _____ Do you chew tobacco? ☐ Yes ☐ No

REVIEW OF SYSTEMS – Do you *CURRENTLY OR RECENTLY* experience(d) any of the following:

Please circle specific problems below	YES	NO	If yes, **please explain**:
General (i.e. fever, unexpected weight loss/gain, night sweats or fatigue)	☐	☐	________________________
Ear/nose/throat (i.e. hearing loss, infections, sore throat, sinusitis)	☐	☐	________________________
Cardiac (i.e. chest pain, irregular heartbeat, palpitations)	☐	☐	________________________
Respiratory (i.e. shortness of breath, wheezing or cough)	☐	☐	________________________
Hay fever or seasonal allergies	☐	☐	________________________
Gastrointestinal (i.e. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	________________________
Urinary or genital (i.e. pain with urination, frequency, blood in urine)	☐	☐	________________________
Skin (i.e. rashes, dryness, rosacea, acne, non-healing sores, moles)	☐	☐	________________________
Musculoskeletal (i.e. back pain, muscle aches, joint pain or swelling)	☐	☐	________________________
Neurological (i.e. numbness, weakness, slurred speech, headaches, seizures)	☐	☐	________________________
Endocrine (i.e. frequent urination, excessive thirst, missed periods, heat or cold intolerance, unexplained lactation, hot flashes)	☐	☐	________________________
Psychiatric (i.e. depression, sadness, mania, hallucinations, anxiety)	☐	☐	________________________

► Patient signature____________________________________ **Date:** ____________________

*** If someone other than the patient completed this form, please write your name and relationship to the patient:*
Name: ________________________________ Relationship: ______________________ Date: ____________

(M.D. reviewed all patient history and ROS: Dr. Reinhardt ___________________ Dr. Kenny __________________ Date ___________)