

Name: _____ Today's Date ____ / ____ / ____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alt Phone: _____ Referred By: _____
 Guardian (If Applicable): _____ Occupation: _____
 Birth Date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Email: _____
 Name of Medical Doctor: _____ Dr.'s Phone: _____
 Vision Insurance _____ Medical Insurance _____ Last Eye Exam: ____ / ____ / ____
 Insurance companies require that we record your weight and height: Weight _____ lbs. Height ____ ft ____ inches
 My preferred pharmacy is: _____
 What is the main reason for your visit? _____

Medical History

Do you have any allergies to medications? no yes If yes, explain:

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies: _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

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? no yes

Family History

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

DISEASE/CONDITION	NO	YES	? Not Sure	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes

If yes, please describe: _____

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

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

SYSTEM	NO	YES	NOT SURE	SYSTEM	NO	YES	NOT SURE
CONSTITUTIONAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EARS, NOSE, MOUTH, THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Doctor's Signature

Date

LIFESTYLE QUESTIONNAIRE

NAME _____ DATE _____

OCCUPATION _____ YEARS _____ EMPLOYER _____

This questionnaire is designed to assist your eye care professional in helping you select the appropriate lenses, frames and/or contact lenses to suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

1. Which of the following activities do you participate in? (Check all that apply)

- | | | | |
|-----------------|--------------------------------|-------------------------------------|---------------------------------------|
| Reading | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Watching TV | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Driving | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |
| Sports/Exercise | <input type="checkbox"/> Daily | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally |

- Computer
- Desktop
 - Laptop
 - Handheld

Hours per day .
Distance from screen .
(iPhone, Blackberry, etc.)

- HOBBIES**
- Arts/Crafts
 - Boating
 - Drawing/Painting
 - Fishing
 - Hunting/Shooting
 - Landscaping/Gardening
 - Musical instrument
 - Photography

- Pilot
- Sewing
- Video Games
- Woodwork
- Other: _____

- SPORTS**
- Biking
 - Golf
 - Running
 - Scuba-diving
 - Skiing
 - Swimming
 - Tennis
 - Other: _____

2. Are your eyes bothered by glare from any of the following situations:

- | | | |
|---|--|---|
| <input type="checkbox"/> Car headlights | <input type="checkbox"/> Haze | <input type="checkbox"/> Sunshine |
| <input type="checkbox"/> Computer monitor | <input type="checkbox"/> Night driving | <input type="checkbox"/> Traffic lights |
| <input type="checkbox"/> Fluorescent lights | <input type="checkbox"/> Snow | <input type="checkbox"/> Other: _____ |

3. What do you like about your current glasses or contacts?

- GLASSES**
- Color
 - Style
 - Lens
 - Fit
 - Brand
 - Other: _____

- CONTACTS**
- Fit
 - Comfort
 - Other: _____

4. What don't you like about your current glasses or contacts?

- GLASSES**
- Thickness
 - Glare
 - Weight
 - Other: _____

- CONTACTS**
- Dryness
 - Comfort
 - Other: _____

QUEEN ANNE
VISIONCLINIC

535 4TH AVE W SEATTLE, WA 98119 (206) 281 - 9100



NAME: _____

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail. **I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Queen Anne Vision Clinic.**

SIGNATURE _____ DATE _____

Financial Disclaimer

Eligibility for medical insurance and/or routine vision benefits

We will attempt to verify your plan eligibility for services and/or materials before your appointment. *Verification of eligibility is done as a courtesy only and is not a guarantee of payment.* Please check with your plan administrator if you have any questions regarding your eligibility. Queen Anne Vision Clinic participates in select HMO plans.

Liability

I understand that account balances and co-payments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to pay Queen Anne Vision Clinic directly. I authorize Queen Anne Vision Clinic to release any information required for payment to be made. *If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full for the remaining balance.* My signature below verifies that I understand the above financial disclaimers.

SIGNATURE _____ DATE _____

Contact Lens Fitting Fees

Contact lens patients require additional diagnostic services every year, which are **not included in the annual eye health evaluation.** The additional fee associated with the contact lens fitting is particular to each patients needs. The fee covers any visits related to contact lens care and any fitting changes for 90 days. After the 90 days, there will be an additional cost for any fitting changes, which will be half of what your original fitting fee was. For first time contact lens wearers, there is a teaching fee along with the contact lens fitting fee. **My signature below verifies that I would like to have a contact lens fitting.**

SIGNATURE _____ DATE _____

Digital Retinal Imaging

During your comprehensive exam we will be performing Digital Retinal Imaging (DRI). This technology involves capturing a high-resolution digital image of the interior portion of your eye. This provides us with a digital retinal fingerprint and serves as a baseline for eye-health comparison on future visits. It's the gold standard for preventative care and disease management. The fee for the Digital Retinal Imaging is **\$39.00** and is **not covered by insurance.** If you opt to not do the Digital retinal imaging, we will have to Dilate your eyes. Dilation drops can cause blurred vision, sensitivity to light, and can last anywhere from 2-4 hours, depending on the person. Please initial below whether you would like to do the Digital Retinal Imaging or the Dilation Drops. Initial on the line.

_____ **I ELECT TO HAVE THE DIGITAL RETINAL IMAGING**
(I understand the doctor may recommend both Digital Retinal Imaging and dilation, depending on each patients specific need)

_____ **I DECLINE THE DIGITAL RETINAL IMAGING AND ELECT TO HAVE A DILATED EXAM**