QUEEN ANNE VISION CLINIC

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	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other_____	☐	☐	☐	

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	☐	☐	☐	**EARS, NOSE, MOUTH, THROAT**	☐	☐	☐
Fever, Weight loss/gain	☐	☐	☐	Allergies/Hay Fever	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐	Sinus Congestion	☐	☐	☐
NEUROLOGICAL	☐	☐	☐	Runny Nose	☐	☐	☐
Headaches	☐	☐	☐	Post-Nasal Drip	☐	☐	☐
Migraines	☐	☐	☐	Chronic Cough	☐	☐	☐
Seizures	☐	☐	☐	Dry Throat/Mouth	☐	☐	☐
EYES	☐	☐	☐	**RESPIRATORY**	☐	☐	☐
Loss of Vision	☐	☐	☐	Asthma	☐	☐	☐
Blurred Vision	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Distorted Vision	☐	☐	☐	Emphysema	☐	☐	☐
Loss of Side Vision	☐	☐	☐	**VASCULAR/CARDIOVASCULAR**	☐	☐	☐
Double Vision	☐	☐	☐	Diabetes	☐	☐	☐
Dryness	☐	☐	☐	Heart Pain	☐	☐	☐
Mucous Discharge	☐	☐	☐	High Blood Pressure	☐	☐	☐
Redness	☐	☐	☐	Vascular Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐	**GASTROINTESTINAL**	☐	☐	☐
Itching	☐	☐	☐	Diarrhea	☐	☐	☐
Burning	☐	☐	☐	Constipation	☐	☐	☐
Foreign Body Sensation	☐	☐	☐	**GENITOURINARY**	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐	Genitals/Kidney/Bladder	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	**BONES/JOINTS/MUSCLES**	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Chronic Infection of Eye	☐	☐	☐	Muscle Pain	☐	☐	☐
Chronic Infection of Lid	☐	☐	☐	Joint Pain	☐	☐	☐
Sties or Chalazion	☐	☐	☐	**LYMPHATIC/HEMATOLOGIC**	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	Anemia	☐	☐	☐
Tired Eyes	☐	☐	☐	Bleeding Problems	☐	☐	☐
ENDOCRINE	☐	☐	☐	**ALLERGIC/IMMUNOLOGIC**	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐	**PSYCHIATRIC**	☐	☐	☐

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	☐ Daily	☐ Frequently	☐ Occasionally
Watching TV	☐ Daily	☐ Frequently	☐ Occasionally
Driving	☐ Daily	☐ Frequently	☐ Occasionally
Sports/Exercise	☐ Daily	☐ Frequently	☐ 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:

☐ Car headlights
☐ Computer monitor
☐ Fluorescent lights
☐ Haze
☐ Night driving
☐ Snow
☐ Sunshine
☐ Traffic lights
☐ 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 VISION CLINIC
535 4TH AVE W SEATTLE, WA 98119 (206) 281 - 9100

SPEED™ QUESTIONNAIRE

Name: _____ **Date:** ___/ ___/ ___ **Sex:** **DOB:**___/ ___/ ___

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ **YES** ☐ **NO.** **If yes, how often?** _____

Adapted from Cornea. 2013 Sep;32(9): 1204- 10

For office use only
Total SPEED score (Frequency + Severity) = ____/28

QUEEN ANNE VISION CLINIC

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.**

DATE _____ **SIGNATURE** _____

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 only 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.

DATE _____ **SIGNATURE** _____

Contact Lens Fitting Fees

Contact lens patients require additional diagnostic services every year, which is **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 which will be half of what your original fitting fee was. For first time contact lens wearers, there is a $35 teaching fee along with the contact lens fitting fee. **My signature below verifies that I would like to have a contact lens fitting.**

DATE _____ **SIGNATURE** _____

iWellness Exam

During your comprehensive exam we will be performing Digital Retinal Imaging (DRI) and OCT Screening.. 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 iWellness Screening is **$42.00** and is **not covered by insurance**. If you opt to not do the iWellness Screening, we will Dilate your eyes. Dilation drops cause blurred vision, sensitivity to light, and can last 2-4 hours, depending on the person. Please initial below whether you would like to do the iWellness Screening or the Dilation Drops.

_____ **I ELECT TO HAVE THE iWELLNESS SCREENING**
I understand the doctor may recommend the iWellness Screening and dilation, depending on each patient's specific needs)

_____ **I DECLINE THE IWELLNESS SCREENING AND ELECT TO HAVE A DILATED EXAM**

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for purposes of validity, enforceability, and admissibility.