

# ISSAQUAH EYEWORKS - WELCOME FORM

## PATIENT INFORMATION

Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Initial

How did you hear about us? \_\_\_\_\_

## GENERAL HEALTH - PATIENT

Name of Physician: \_\_\_\_\_ Clinic Name \_\_\_\_\_

Physician Phone Number \_\_\_\_\_ Date of last medical exam \_\_\_\_\_

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Allergies / Hay Fever    | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Psychiatric / Depression    |
| <input type="checkbox"/> Asthma / Respiratory     | <input type="checkbox"/> Chronic Cough      | <input type="checkbox"/> Headaches / Migraines     | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Blood Disorders          | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Attack / Stroke     | <input type="checkbox"/> Skin Disorders              |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Thyroid / Endocrine Disease |
| <input type="checkbox"/> Cardiovascular / High BP |   |  | <input type="checkbox"/> Weight Loss / Gain          |

Arc you pregnant or nursing  Yes  No

Do you have any allergies to medications?  Yes  No If yes, explain \_\_\_\_\_

List any current medications \_\_\_\_\_

List any major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

## FAMILY MEDICAL HISTORY - BLOOD RELATIVES

Please indicate relationship of family member if any of the following are selected.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Lazy Eye _____            | <input type="checkbox"/> Color Blindness _____    | <input type="checkbox"/> High Cholesterol _____      |
| <input type="checkbox"/> Arthritis _____           | <input type="checkbox"/> Diabetes _____           | <input type="checkbox"/> Blindness _____             |
| <input type="checkbox"/> Eye Turn _____            | <input type="checkbox"/> Cancer _____             | <input type="checkbox"/> Glaucoma _____              |
| <input type="checkbox"/> Cataract(s) _____         | <input type="checkbox"/> Thyroid Disease _____    | <input type="checkbox"/> Stroke / Heart Attack _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Retinal Detachment _____ | <input type="checkbox"/> Macular Degeneration _____  |

## SOCIAL HISTORY

Do you drive?  Yes  No

Do you use tobacco products?  Yes  No If yes, type/amount/how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, type/amount/how long? \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/amount/how long? \_\_\_\_\_

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

I would prefer to discuss my social history directly with my doctor.

## EYE HEALTH HISTORY

Please check all that apply:

Date of last Eye Exam \_\_\_\_\_

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Amblyopia (lazy eye)     | <input type="checkbox"/> Eye Surgeries             | <input type="checkbox"/> Itchy Feeling            |
| <input type="checkbox"/> Blurred Vision – Far     | <input type="checkbox"/> Eye Turn                  | <input type="checkbox"/> Infection of Eye / Lid   |
| <input type="checkbox"/> Blurred Vision – Near    | <input type="checkbox"/> Floaters / Spots          | <input type="checkbox"/> Loss of Vision – Central |
| <input type="checkbox"/> Burning Eyes             | <input type="checkbox"/> Fluctuating Vision        | <input type="checkbox"/> Loss of Vision - Side    |
| <input type="checkbox"/> Cataracts                | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Mucus / Discharge        |
| <input type="checkbox"/> Double /Distorted Vision | <input type="checkbox"/> Glare / Light Sensitivity | <input type="checkbox"/> Redness                  |
| <input type="checkbox"/> Drooping Eyelid          | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Retinal Detachment       |
| <input type="checkbox"/> Dry Eyes                 | <input type="checkbox"/> Infection of Eye / Lid    | <input type="checkbox"/> Tearing / Watery Eyes    |

## GENERAL VISION QUESTIONNAIRE

Do you wear glasses?  Yes  No

If Yes, how old is your current pair of lenses? \_\_\_\_\_

Do you have trouble driving at night?  Yes  No

Do you experience blur, headaches or eyestrain with computer use?  Yes  No

Are you interested in laser (refractive) surgery to correct your vision?  Yes  No  Maybe

## CONTACT LENS QUESTIONNAIRE

Do you wear contacts?  Yes  No If Yes, What Type? \_\_\_\_\_

Are your contact lenses comfortable?  Yes  No

How frequently do you replace your contacts? \_\_\_\_\_

What type of contact lens solution do you use?  Opti-Free - GP  Boston Advance

Boston Simplus  RevitaLens  Clear Care  Opti-Free  Bio-true

Do you have any concerns about your current contacts? \_\_\_\_\_

*As a contact lens wearer, you should have an annual contact lens exam. During this exam, the doctor will assess the contact lens fit, check parameters and look for any medical issues arising from contact lens wearing. A written prescription good for one year will be written. If you do not elect to have a contact lens exam, you will not have a current prescription to purchase contacts.*

Do you wish to have a contact lens exam today?

Yes  No, I do not wish to have a current contact lens prescription.

The fees associated with a contact lens exam are particular to each patients needs, and are in addition to your comprehensive eye exam. The insurance coverage of these fees is unique to each insurance plan.

Please feel free to ask our staff for more information. **Please Initial:** \_\_\_\_\_

Soft Spherical Range: \$49-\$69 Soft Toric Range: \$54-\$90 Soft Bifocal Range: \$64-\$100 Soft Bifocal/Toric Range: \$74-\$120  
RGP Spherical Range: \$49-\$85 RGP Toric Range: \$74-\$125 RGP Bifocal Range: \$94-\$154 RGP Bifocal/Toric Range: \$110-\$170  
CRT \$1500 Initial fitting fee w/CRT lenses CRT Range: \$99-\$300