Dr. Jeffrey Lind • Tanasbourne Vision Center • 7129 NE Imbrie Dr, Hillsboro, OR, 97124

Name:_____ Male/Female Today's Date:_____/_____/_____

Address:_____ Home phone:_____

City_____State_____Zip_____ Work phone_____

Birth Date: _____/_____/_____ Social Security #_____ Occupation_____

Email address_____

Last Eye Exam: _____/_____ Married/Single OR Parent /Guardian_____

Vision Insurance_____ ID#_____Insured_____

Medical History Last Medical Exam:____/_____ Medical Doctor:_____ Dr's Phone:_____

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

_____

List any medications you are taking (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

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

_____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease,

cataracts, eye infections, eye injury or other_____

Are you pregnant and/or nursing? □ no □ yes

Do you wear glasses? □ no □ yes If yes, how old are your present lenses? _____

Do you wear contact lenses? □ no □ yes If yes, what type and how old are they? _____

Family History: Check all conditions that run in your family (parents, grandparents, siblings, children; living or deceased).

RELATIONSHIP TO YOU

☐ Blindness_____

☐ Crossed Eyes _____

☐ Glaucoma _____

☐ Macular Degeneration _____

☐ Retinal Detachment/Disease _____

☐ Arthritis _____

☐ Cancer _____

☐ Diabetes _____

☐ Heart Disease _____

☐ High Blood Pressure _____

☐ Kidney Disease _____

☐ Lupus _____

☐ Thyroid Disease _____

☐ Other _____

Please turn this form over and complete side two

Social History ***This information is kept strictly confidential. However you may discuss this directly with the doctor if you prefer.***

Do you drive? □no □yes Do you have visual difficulty when driving? □no □yes Describe:_____

Do you use tobacco products? □no □yes What type /amount / how long? _____

Do you drink alcohol? □no □yes What type / amount / how long?_____

Do you use illegal drugs? □no □yes What type / amount / / how long? _____

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

REVIEW OF SYSTEMS: Please check all health conditions that apply to **you** and briefly explain:

CONSTITUTIONAL

□Fever, Weight Loss/Gain_____

SKIN

□ Rosacea_____

□Other_____

NEUROLOGICAL

□Headaches_____

□Migraine_____

□Seizures_____

EYES

□Loss of Vision _____

□Double Vision _____

□Blurred Vision _____

□Distorted Vision / Halos _____

□Loss of Side Vision _____

□Dryness _____

□Mucous Discharge _____

□Redness _____

□Sandy or Gritty Feeling _____

□Itching _____

□Burning _____

□Foreign Body Sensation_____

□Excess Tearing/Watering _____

□Glare/Light Sensitivity_____

□Eye Pain or Soreness _____

□Chronic Infection of Eye or Lid _____

□Sties or Chalazion _____

□Flashes/Floaters in Vision _____

□Tired Eyes _____

ENDOCRINE

□Thyroid_____

□Other glands _____

EARS, NOSE, MOUTH, THROAT

□Allergies/Hay Fever _____

□Sinus Congestion _____

□Runny Nose_____

□Ear Infections_____

□Post-Nasal Drip _____

□Chronic Cough _____

□Dry Throat/ Mouth _____

RESPIRATORY

□Asthma_____

□Chronic Bronchitis_____

VASCULAR / CARDIOVASCULAR

□Diabetes _____

□Heart Pain _____

□High Blood Pressure _____

□Vascular Disease _____

GASTROINTESTINAL

□Diarrhea _____

□Constipation _____

□Indigestion_____

GENITOURINARY

□Genitals/Kidney/Bladder _____

BONES / JOINTS/ MUSCLES

□Rheumatoid Arthritis_____

□Muscle Pain_____

□Joint Pain_____

LYMPHATIC / HEMATOLOGIC

□Anemia_____

□Bleeding Problems_____

□**ALLERGIC/IMMUNOLOGIC** _____

□**PSYCHIATRIC**_____

Please list any health conditions not listed above, and briefly explain:_____

_____

□ All else negative

_____ _____

Patient Signature **Date** **Doctor Signature** **Date**