**WHITE SALMON EYECARE**
**Dr. Alex Baldwin, OD**



# PATIENT INFORMATION FOR MINORS

## PATIENT HISTORY

Purpose of today's visit: ☐ Blurry vision ☐ Double vision ☐ Dry eyes ☐ Eye pain

☐ Other: _____

Does the patient wear contacts? ☐ Yes ☐ No ☐ Interested in starting

### Social History – Does the patient?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Smoke _____ packs/day Years smoked ____ | ☐ | ☐ | Drink Alcohol _____ drinks/day |
| ☐ | ☐ | Former smoker? | ☐ | ☐ | Other drug use: _____ |

### List all eye illnesses and injuries:

- ☐ None
- ☐ Floaters
- ☐ Dry eyes
- ☐ Lazy eye
- ☐ Crossed eye
- ☐ Foreign body
- ☐ Eye infection
- ☐ Tearing
- ☐ Other:
- ☐ Cataracts
- ☐ Diabetic retinopathy
- ☐ Retinal detachment
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Blindness

### List all eye surgeries:

- ☐ None
- ☐ Laser Peripheral Iridotomy (LPI)
- ☐ LASIK
- ☐ Cataract surgery
- ☐ Photorefractive Keratectomy (PRK)
- ☐ Radial Keratotomy (RK)
- ☐ Blepharoplasty
- ☐ Retinal detachment repair
- ☐ Intravitreal injections
- ☐ Pseudophakic surgery
- ☐ Other:

### List all major illnesses or injuries:

- ☐ None
- ☐ Heart arrhythmia
- ☐ Dementia
- ☐ Anxiety
- ☐ Headaches
- ☐ Hypertension
- ☐ Other:
- ☐ Heart disease
- ☐ Cancer: Type _____
- ☐ High cholesterol
- ☐ Asthma
- ☐ Hypothyroid
- ☐ Depression

### List past surgeries the patient has had:

- ☐ None
- ☐ Tonsillectomy
- ☐ Mastectomy
- ☐ Prostatectomy
- ☐ Hysterectomy
- ☐ Other:
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Hip replacement
- ☐ Stent
- ☐ Hernia

### Diabetes

Has the patient ever been diagnosed with Diabetes ☐ **No** (if no, skip to the next section) ☐ **Yes, Type I** ☐ **Yes, Type II**

Year diagnosed: _____

Last A1c: _____ Date measured: _____

**List current eye drops the patient takes:** ☐ **None**

**List current medications the patient takes:** ☐ **None**

**List medication allergies:** ☐ **None**

**Please complete other side →**

**TODAY,** is the patient currently experiencing any problems in the following areas?

**General**

Yes No
- ☐ ☐ Fatigue
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss
- ☐ ☐ Fever

**Ear, Nose, & Throat**

Yes No
- ☐ ☐ Dry mouth
- ☐ ☐ Sinus pressure

**Cardiovascular**

Yes No
- ☐ ☐ Chest pain

**Respiratory**

Yes No
- ☐ ☐ Cough

**Genitourinary**

Yes No
- ☐ ☐ Excessive urination

**Musculoskeletal**

Yes No
- ☐ ☐ Joint pain

**Gastrointestinal**

Yes No
- ☐ ☐ Diarrhea

**Skin**

Yes No
- ☐ ☐ Rashes

**Neurological**

Yes No
- ☐ ☐ Headaches
- ☐ ☐ Numbness

**Psychiatric**

Yes No
- ☐ ☐ Anxiety

**Endocrine**

Yes No
- ☐ ☐ Heat/Cold intolerance
- ☐ ☐ Excessive thirst

**Blood/Lymph**

Yes No
- ☐ ☐ Easily bruises
- ☐ ☐ Easily bleeds

**Allergic/Immunological**

Yes No
- ☐ ☐ Seasonal

**Other**

Yes No
- ☐ ☐ Pregnant
- ☐ ☐ Nursing

Other Health Problems: _____

_____

## FAMILY HISTORY

Please check the box of the **family member** who has had any of the following medical conditions:

M = Mother F = Father S = Sibling GP = Grandparent

| | M | F | S | GP |
|---|---|---|---|---|
| Glaucoma | | | | |
| Retinal detachment | | | | |
| Cataracts | | | | |
| Crossed or Lazy eye | | | | |
| Macular degeneration | | | | |
| Blindness | | | | |
| Other: _____ | | | | |

| | M | F | S | GP |
|---|---|---|---|---|
| Diabetes | | | | |
| Hypertension | | | | |
| High cholesterol | | | | |
| Thyroid | | | | |
| Cardiovascular | | | | |
| Cancer | | | | |
| Other: _____ | | | | |

## Signatures

**Assignment of Benefits:** I hereby authorize White Salmon Eyecare to provide my insurance company with information concerning my care and services rendered, assign all benefits to them, and to receive direct payment of insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and that it is the policy of White Salmon Eyecare to receive payment at the time of service.

**HIPAA Privacy Notice:** In the course of providing service to you, we create, receive, and store protected health care information that identifies you. It is often necessary to use and disclose this health care information for the purposes of treatment, payment, and health care operations involving our office. The Notice of Privacy Practices is located at the front reception desk and describes these policies in detail. By signing below, I acknowledge I was given the opportunity to review the Notice of Privacy Practices.

**Authorization to provide care:** I hereby authorize White Salmon Eyecare to provide routine and medical eye care services to my child. If I will not be present during the exam, I give consent for my child to receive routine and medical care, including dilation, without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred during these appointments.

Printed Name of Signer: _____ Relationship to patient: _____

Signature: _____ Date: _____

Patient Name: _____ Date of birth: _____