WHITE SALMON EYECARE
Dr. Alex Baldwin, OD

PATIENT INFORMATION

PATIENT HISTORY

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

☐ Other: _____

Do you wear contacts? ☐ Yes ☐ No ☐ Interested in starting

Social History – Do you?

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 you have had:

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

Diabetes

Have you 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 you take: ☐ **None**

List current medications you take: ☐ **None**

List medication allergies: ☐ **None**

Please complete other side →

TODAY, are you 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: _____				

Patient 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.

Printed Name: _____

Signature: _____ Date: _____