GARLAND
VISION SOURCE®
DRS. HAGEN & HEDLUND
521 W. GARLAND • SPOKANE, WA 99205 • **P** (509) 327-9505

Today's date: _____

PATIENT INFORMATION

Last: _____ First: _____ MI: _____
Date of Birth: _____ Age: _____ Sex: M F
Height: _____ Weight: _____
Address: _____
City: _____ State: _____ Zip: _____
Home / Daytime Phone: _____
Cell Phone: _____
E-Mail Address: _____
Patient's SSN: _____
Employer (or School): _____
Occupation (or Grade): _____
Spouse (or Parent's) Name: _____
Spouse (or Parent's) Phone: _____
Date of Last Eye Exam: _____
Referred by : _____

INSURANCE INFORMATION

Primary Medical Insurance Co: _____
Vision Insurance Co: _____
Subscriber's Name: _____
Subscriber's DOB: _____
Identification#: _____
Group#: _____

PATIENT'S MEDICAL HISTORY

Primary Care Physician: _____
Current Medications (please list the names of all Rx and over the counter medications, including any eye drops, multi vitamins and/or birth control pills): _____

Allergies to Medications: ☐ Yes ☐ No
If Yes, Please List: _____

The Federal Government now requires us to collect the following information (please choose only **ONE ANSWER** for each category):

Language:
☐ English ☐ Spanish ☐ Japanese
☐ French ☐ Russian ☐ Other

Race:
☐ White ☐ Hispanic
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other ☐ Decline to Answer

Ethnicity:
☐ Caucasian ☐ Hispanic/Latino ☐ African American
☐ Native American ☐ Native Hawaiian ☐ Asian
☐ German ☐ Russian ☐ Other
☐ Decline to Answer

Please communicate with me via:
☐ Phone ☐ E-Mail ☐ Postal

What is your birth order? _____ ☐ Only Child?

Do you smoke? ☐ Yes ☐ No
Packs per day? _____
If former smoker, how long ago did you quit? _____

Do you drink alcoholic beverage? ☐ Yes ☐ No
☐ Social Only ☐ 1-2 Drinks Daily ☐ Alcohol Dependence

Do you use narcotics? ☐ Yes ☐ No
☐ Recreational Use ☐ Chemical Dependence

Do you have a history of sexually transmitted diseases?
☐ Yes ☐ No

Do you have a history of blood transfusion? ☐ Yes ☐ No

Please check all that apply:

☐ Do you currently wear prescription glasses?
☐ Do you currently wear contact lenses?
☐ Do you wear bifocals or trifocals?
If so, are you bothered by the lines? ☐ Yes ☐ No
☐ Do you have more than one pair of current prescription glasses?
☐ Do you have prescription sunglasses?
☐ Have you had LASIK or PRK? If so, what year? _____

Have you ever been diagnosed or treated for:
☐ Allergies ☐ Asthma ☐ Arthritis
☐ Cancer ☐ Diabetes ☐ High Cholesterol
☐ High Blood Pressure ☐ Kidney Disease
☐ Thyroid Disease ☐ Other _____

Have you ever been diagnosed or treated for:
☐ Amblyopia/Lazy Eye ☐ Cataracts
☐ Corneal Abrasion ☐ Eye Injury
☐ Glaucoma ☐ Iritis
☐ Macular Degeneration ☐ Retinal Detachment
☐ Other _____

Are you currently experiencing any of the following?
☐ Blurry Vision ☐ Burning ☐ Crossed / Turned Eye
☐ Double Vision ☐ Excessive Tearing ☐ Flashes of Light
☐ Floaters / Spots ☐ Dry Eyes ☐ Headaches
☐ Itchiness ☐ Sunlight Sensitivity
☐ Trouble seeing at night

Do you have a family history of any of the following?
☐ Blindness ☐ Cataracts ☐ Glaucoma
☐ Retinal Problems ☐ Corneal Problems ☐ Diabetes
☐ Macular Degeneration