Appointment Date:_____
Time: _____

WELCOME TO MT. HOOD VISION CENTER
Mark A. George, O.D
22640 S.E. Stark, Gresham, OR 97030
(503) 667-0441

Date: _____
Patient Name: _____ Date of Birth _____
Address: _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
Parent/Guardian _____ Ph Number _____ Cell Phone _____
How did you hear of our office? _____
If someone referred you, please indicate name _____
May we use your name in thanking this person? Y N
May we contact you by email? Y N If yes, email address _____

SOCIAL HISTORY

Current Occupation _____
Marital Status (circle one) Single Married Widowed Divorced
Tobacco Use:
- □ Never smoked
- □ Former Smoker stopped smoking: □ within last year □ 1 to 2 yrs □ 3 to 4 yrs □ 4 to 5 yrs □ 5 + years
- □ Current Smoker □ everyday □ some day smoker When did you start smoking? _____
  - □ heavy smoker □ light smoker (1 to 9 cigarettes per day)
- □ Current Smokeless Tobacco user

Alcohol Use:
□ None □ Social Use □ 1 – 2 per day □ Alcohol Dependence
Narcotic Use:
□ None □ Recreational Use □ Chemical Dependence
Sexually Transmitted Disease:
□ None □ Yes □ HIV Positive
Blood Transfusion:
□ None □ Yes □ HIV Positive
Birth Order:
□ First □ Second □ Third □ Fourth □ Fifth □ > Fifth □ Only Child
□ Identical Twin □ Fraternal Twin

MEDICAL HISTORY

List any medications you take: _____

List any allergies to medications: _____

List all major illnesses or injuries (diabetes, high blood pressure, emphysema, heart attacks, whiplash , cancer)

List any surgeries you have had: _____

List all eye illnesses or injuries (crossed/lazy eye, cataract, glaucoma, macular degeneration, retinal detachments, abrasions, etc.) _____

TURN OVER

Do you **CURRENTLY** have any problems in the following areas? If Yes, please explain problem.

	Yes	No	
General / Constitutional (fever, weight loss, other)	☐	☐	
Ears, Nose and Throat (cold, sinus, chronic cough)	☐	☐	
Cardiovascular (heart, vessels etc.)	☐	☐	
Respiratory (asthma, emphysema, etc.)	☐	☐	
Gastrointestinal (ulcers, intestinal disease, etc.)	☐	☐	
Genital, Kidney, Bladder	☐	☐	
Skin (rosacea skin cancer, psoriasis, etc.)	☐	☐	
Neurological (MS, stroke, seizures, etc.)	☐	☐	
Psychiatric (anxiety, depression, etc.)	☐	☐	
Endocrine (diabetes, thyroid, etc.)	☐	☐	
Blood / Lymph (bleeding disorder, high cholesterol, anemia, etc.)	☐	☐	
Allergic / Immunologic (Lupus, hay fever, rheumatoid arthritis, etc.)	☐	☐	
Skeleto-Muscular (chronic joint or muscle pain)	☐	☐	

Do you have a **FAMILY** history of:	Yes	No	Relationship to patient
Blindness	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Diabetes	☐	☐	
Hypertension / Heart Disease	☐	☐	

PREVIOUS EYE DOCTOR INFORMATION

Last Eye Examination Date _____
Prior Eye Doctor's Name _____
Address _____
Phone: _____

PRIMARY CARE DOCTOR INFORMATION

Doctor's Name _____
Address _____
Phone _____
Last Physical Exam _____

OTHER SPECIALTY CARE DOCTOR INFORMATION

Doctor's Name _____
Address _____
Phone _____