Appointment Date: _____
Time: _____

WELCOME TO MT. HOOD VISION CENTER

O. Keene Clay, O.D., FCOVD

22640 S.E. Stark
Gresham, OR 97030
(503) 667-0441

Mark A. George, O.D.

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 _____

PATIENT MEDICAL HISTORY

List any medications you take:

_____
_____
_____
_____

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

_____
_____
_____

Do you have any allergies to medications?
If Yes, please list the medications: _____
_____
_____

List any surgeries you have had:

_____
_____
_____

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

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.)	☐	☐	_____
Skeloto-Muscular (chronic joint or muscle pain)	☐	☐	_____

TURN OVER

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

Social History

Current Occupation _____
Marital Status (circle one) Single Married Widowed Divorced
Do you live in □ own home □ with relatives □ retirement facility □ other _____
Do you smoke? □ Yes □ No (If Yes)_____ packs/day
Do you drink alcohol? □ Yes □ No (If Yes) _____drinks/day
Do you use illegal drugs? □ Yes □ No If Yes, explain _____
Pregnant / Nursing □ Yes □ No If Yes, explain _____

VISUAL INFORMATION

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

VISUAL SYMPTOMS (check any significant problem areas)

□ Blur at distance	□ Sleepy when reading	□ Eyes water often	□ Motion sensitivity riding in car
□ Blur at near	□ Hold reading at 10@ or less	□ Redness of Eyes	□ Fear of Heights
□ Pain in or around eyes	□ Frequent loss of place	□ Eye Pain	□ Dizziness/balance problems
□ Squinting	□ Double Vision/Eye Turn	□ Mucus Discharge	□ Light sensitivity
□ Poor night vision	□ Blindness	□ Crusting of lids	□ Flashes/floaters
□ Transient Blur	□ Temporary loss of vision	□ Eyes burn/Itch	□ Print dances or moves
□ Seizures	□ Headache / migraine	□ Distorted vision/Halos	

CONTACT LENSES

Current contact lens wearer □ Yes □ No
Contact lens brand or style: _____ What solution do you use? _____

STUDENTS

Current Grade _____ Have you ever skipped/repeated a grade? □ Yes □ No Grade repeated: _____
Do you read at or above grade level? □ Yes □ No Do you read for pleasure? □ Yes □ No
Have you been tested or treated for: Hyperactivity ADD ADHD Learning Disability
Most common letter grades: AB BC CD DF
Are your parents satisfied with your current level of progress and performance? □ Yes □ No

Your Medical Doctor's Name _____Last Physical Exam _____
Address _____
Phone_____

Updates _____