EagleEye VISION CARE LLC

4048 River Road North
Keizer, OR 97303-5501
503-385-8361 ~ Phone
503-385-8364 ~ Fax
www.EagleEyeVisionCare.com

ADULT VISION QUESTIONNAIRE

It is our pleasure to serve you.

Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Work Phone: _____
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address _____
Do you have Major Medical Insurance? Yes ☐ No ☐
If yes, who is the carrier? _____ Policy #: _____
Does the insurance cover eye examinations or glasses? Yes ☐ No ☐
Name of Insured: _____
Social Security Number: _____ Driver's License No.: _____
What is your occupation? _____ Employer: _____
Please list the names and birth dates of your spouse and dependents:

	NAME	
Spouse	_____	Birth Date _____
Dependents	_____	Birth Date _____
	_____	Birth Date _____
	_____	Birth Date _____
	_____	Birth Date _____

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Blindness	☐	☐	_____	Eye Infections	☐	☐	_____
Eye Turn	☐	☐	_____	Thyroid Condition	☐	☐	_____
Glaucoma	☐	☐	_____	Eye Surgery	☐	☐	_____
Cancer	☐	☐	_____	Cataracts	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Lazy Eye	☐	☐	_____
Brain Tumor	☐	☐	_____	Eye Disease	☐	☐	_____

Physician's Name: _____ Date of Last Evaluation: _____
For what problem / condition? _____
Results and recommendations: _____
Medications currently using including vitamins and supplements: _____
_____
For what condition(s)? _____
Are you allergic to any foods or medications? Yes ☐ No ☐
If yes, please list: _____
Current diet: Good ☐ Fair ☐ Poor ☐
Current state of health (explain): _____

VISUAL HISTORY

Main reason for having an examination today: _____
Date of Last Evaluation: _____ Doctor's name: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses or other optical devices recommended? Yes ☐ No ☐
If yes, are they used? Yes ☐ No ☐ If yes, when? _____
If no, why not? _____
Are there any problems with your current optical prescription? Yes ☐ No ☐
If Yes describe: _____
If you wear contact lenses, what type are they? Soft ☐ Rigid ☐ Gas Permeable ☐
How long have you worn them? _____
If not worn full time, when do you wear them? _____
How old are your current contact lenses? _____ What solutions do you use? _____

_____

Do you experience any of the following:	**Yes**	**No**	**If yes, when?**
Headaches	☐	☐	_____
Blurred vision	☐	☐	_____
Double vision	☐	☐	_____
Nausea when doing visual tasks	☐	☐	_____
Motion/car sickness	☐	☐	_____
Halos around lights	☐	☐	_____
Need for bright light	☐	☐	_____
Need for dim light	☐	☐	_____
Eyes "hurt" or "tired"	☐	☐	_____
Eyes itch	☐	☐	_____
Eyes burn	☐	☐	_____
Eyes tear	☐	☐	_____
Eyes frequently reddened	☐	☐	_____
Closing or covering one eye	☐	☐	_____
Lose place while reading	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Difficulty maintaining attention when reading	☐	☐	_____
When reading, letters/words appear to move or float around	☐	☐	_____

Do your work or leisure time activities involve any eye hazards? Yes ☐ No ☐ Explain: _____
If yes, is protective eyewear worn? _____
Do you use a computer? Yes ☐ No ☐ If yes, how many hours a day? _____
Please enter the following computer working distances:
eyes to the: screen: _____ keyboard: _____ source document: _____
Please describe any problems you have with your current glasses or contact lenses for computer work:

_____
Any visual symptoms after using your computer? _____
Does your work/leisure activities require comprehension of the written word? Yes ☐ No ☐
If yes, describe: _____
Have you ever had any blows or injuries to your head, eyes, or neck? Yes ☐ No ☐
If Yes, describe: _____

Do you feel your vision hinders you in any way? Yes ☐ No ☐ If yes, How? _____

List any other questions, concerns you may have regarding your vision: _____

Release Of Information and Insurance Filing:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of Eagle Eye Vision Care LLC it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

_____ _____

Signature of patient or authorized representative Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day / 7 days a week.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Keirsten D. Eagles, O.D., M.Ed.