ICON EYECARE GRAND JUNCTION
1000 Wellington Avenue
Grand Junction, CO 81501
Phone: (970) 256-0400 Toll Free: 800-439-3799
Fax: (970) 256-9149

-PATIENT INFORMATION-

Date_____

Last Name _____ First Name_____ Middle Initial____

Address _____ Phone #1_____ Phone # 2 _____

City _____ State _____ ZIP _____

Email Address_____ Opt-in Patient Portal □Y □N

Date of Birth _____Age _____ Mr.____ Mrs. ____ Miss ____ Ms. ___

Patient's Social Security # (Not Medicare Number) _____Spouse's Name _____

Patient, Single _____ Married _____

Patient's Employer _____ Employer Address _____

Family Physician _____

Nearest Relative or Friend _____/ Relationship _____ Ph. # _____

Referred by Whom _____

Parent or Guardian _____Parent's Social Security Number _____
(if 18 or under)

Parent Employer _____ Ph. # _____
(if 18 or under)

—INSURANCE INFORMATION—

Medicare Number _____Supplemental Insurance _____

Insurance Company Name _____
Subscriber # _____Group # _____
Name of Subscriber (if different from patient): _____ Subscriber's Employer _____
Date of Birth: _____ Social Security #_____ Relationship to patient _____

ON THE JOB INJURY

Date of Injury_____ Employer_____ Ph. # _____

I understand that charges for services must be paid upon receipt of medical services, I also understand that I am responsible for all my financial obligations as a result of the medical services received.

I hereby authorize ICON Eyecare (practice) to provide information to insurance companies concerning the medical services received. Additionally, I hereby assign all insurance payments related to the claims made by this office, in my benefit and for the benefit of my dependents, to ICON Eyecare. I understand that I am responsible for any adjustment or balance not paid to the practice by the insurance company.

Signature _____ Date _____

Medical History Questionnaire

Name: _____ Date Completed: _____

Birth Date: _____Optometrist: _____ Primary Care Provider: _____

Please list all eye drops (including non-prescription or over-the counter drops) that you currently use:

Medication Name and Strength	Which Eye?	Frequency
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	

Do you wear contacts or glasses? Yes / No **How many years have you worn them?** _____

What kind of contact lenses do you wear? Soft / Hard When (if at all) did you stop wearing them? _____

Have you had any eye surgery, laser treatment, or any other ocular procedures? Yes / No **If yes, what, when, and where was it performed?** _____

_____

List all injuries to head or eye area, including date: _____

_____

List any/all surgeries you have had (not including the eye), including date of the surgery: _____

_____

Medical History:

Height: **Weight:**	Are you Pregnant? □ Yes □ No □ NA Are you breastfeeding? □ Yes □ No □ NA
Have you had a flu shot this season? □Yes □No	**If Under the age of 55, when was your last monthly period?**
Do you use tobacco products? □ Current □ Former □ Never	**If current, how much?**
Do you use alcohol? □ Yes □ No □ How Much?	**Do you use recreational drugs?** □ Yes □ No
Any History of falls? □ Yes □ No	**Have you had a pneumonia vaccination this year?** □ Yes □ No

Do you have a history of any of the following:

Methicillin-resistant staphylococcus aureus (MRSA)? □Yes □No If yes, Last Active _____

Clostridium difficile (C-Diff)? □Yes □No If yes, Last Active _____

Shingles? □Yes □No If yes, Last Active _____

History of problems with anesthesia? □Yes □No If yes, please describe: _____

Family History:

Please indicate if you have a blood relative with the following conditions:

Glaucoma? □Yes □No **Macular Degeneration?** □Yes □No **Blindness or Low Vision?** □Yes □No **Diabetes?** □Yes □No

Do you currently, or have you ever had any of the following:

Sleep Apnea or CPAP?	□Yes □No	High Blood Pressure?	□Yes □No
COPD or Emphysema?	□Yes □No	Stroke?	□Yes □No
Asthma?	□Yes □No	Seizures?	□Yes □No
Pulmonary Embolism?	□Yes □No	Tremors?	□Yes □No
Do you use Oxygen	□Yes □No	Paralysis?	□Yes □No
Congestive Heart Failure?	□Yes □No	Thyroid Disorders?	□Yes □No
Heart Disease?	□Yes □No	Kidney Disease?	□Yes □No
Cardiac Arrhythmia?	□Yes □No	Hepatitis?	□Yes □No
Atrial Fibrillation?	□Yes □No	Ulcers?	□Yes □No
Heart Attack?	□Yes □No	BPH (enlarged prostate)?	□Yes □No
Artificial Heart Valves?	□Yes □No	Cancer?	□Yes □No
Pacemaker?	□Yes □No	Diabetes?	□Yes □No
Angina (Chest Pain)?	□Yes □No	If Diabetic, which type?	□Type I □Type II □Other
Vascular Disease?	□Yes □No	Do you use Insulin?	□Yes □No
Blood Coagulation Disorders?	□Yes □No	Dialysis?	□Yes □No
Other:			

Medications:

Are you allergic to any medications that you know of? □Yes □No If yes, please list below:

Medication	Reaction

Have you ever taken Flomax (Tamsulosin)? □Yes □No

Please list all medications you are currently taking, including over the counter vitamins and supplements. If needed, additional space is provided on the next page.

Name of Medication	Strength	Dosage Taken	How Often	Oral, Inhaled, or Injection

Medications:

Name of Medication	Strength	Dosage Taken	How Often	Oral, Inhaled, or Injection

Additional Information:

If you have any additional health history information you would like our doctors to know about, please list it below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Questionnaire for Dry Eye Disease/Ocular Surface Disease Evaluation

Date: ___/___/___

Name:_____ Date of Birth: ___/___/___

Dry Eye Disease is one of the most frequent reasons for visits to eye doctors. Therefore, we ask that you take a few moments and thoughtfully complete the questions below:

Do you have fluctuating vision problems that get better with blinking (circle one)?

Never Sometimes Frequently A lot/always

***FREQUENCY*: How <u>often</u> are you experiencing the following symptoms?**

Symptoms	Never 0	Sometimes 1	Often 2	Constant 3
Dry/Gritty				
Scratchy/Sore				
Irritation				
Burning/Watering				

***SEVERITY*: How <u>bothersom</u>e are the following symptoms that you're experiencing:**

Symptoms	**Never-0** No problems	**Tolerable-1** Not perfect, not uncomfortable	**Uncomfortable-2** Irritating. Does not interfere with my day	**Bothersome-3** Irritating. Affects my day	**Intolerable-4** Unable to perform my daily tasks
Dry/Gritty					
Scratchy/Sore					
Irritation					
Burning/Watering					

Mark an X if you had these symptoms:

[ ]Today [ ]in the past 72 hours [ ]in past 3 months

Do you use eye Drops? □Yes □No

Have you used them in the past 2 hours? □Yes □No

For office use only:

SPEEDscore:

tOSM:____/____

Name of eye drops/ointments and usage: _____

_____

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Pre Surgical Cataract Patient Questionnaire

Patient Name: _____
Date: _____
Chart Number: _____
Eye Being Evaluated: □Right Eye □Left Eye

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?

	YES	NO
1) Reading small print, such as labels on medicine bottles, telephone books or food labels?	□	□
2) Reading a newspaper or book?	□	□
3) Reading a large-print book or large-print newspaper?	□	□
4) Recognizing people when they are close to you?	□	□
5) Seeing steps, stairs or curbs?	□	□
6) Reading traffic signs, street signs or store signs?	□	□
7) Doing fine handwork like sewing, knitting, crocheting or carpentry?	□	□
8) Writing checks or filling out forms?	□	□
9) Playing games such as bingo, dominoes or card games?	□	□
10) Taking part in sports like bowling, handball, tennis or golf?	□	□
11) Cooking?	□	□
12) Watching television?	□	□

SYMPTOMS

Have you been bothered by the following?

	YES	NO
1) Poor night vision?	□	□
2) Seeing rings or halos around light?	□	□
3) Glare caused by headlights or bright sunlight?	□	□

Patient Name: _____

Eye Being Evaluated:
□ Right Eye □Left Eye

SYMPTOMS

Have you been bothered by the following

	YES	NO
4) Hazy and/or blurry vision?	□	□
5) Seeing well in poor or dim light?	□	□
6) Poor color vision?	□	□
7) Double vision from one eye?	□	□

DRIVING

1) Have you ever driven a car? □ YES (Continue to Question 2) □ No (Stop Here)

2) Do you currently drive a car? □ YES (Continue to Question 2) □ No (Stop Here)

3) How much difficulty do you have driving during the day because of your vision?

□ No difficulty □ Moderate amount of difficulty
□ Little Difficulty □ Great deal of difficulty

4) How much difficulty do you have driving during at night because of your vision?
□ No difficulty □ Moderate amount of difficulty
□ Little Difficulty □ Great deal of difficulty

5) When did you stop driving?
□ Less than 6 months ago □ 6-12 months ago □ More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision anymore and of the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

□ YES □ NO

Patient Signature: _____ Date: _____

Print Name: _____