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. # _____

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	

List fill **Injuries** (Head or Eye Trauma) and DATE

List fill **Illnesses** (Glaucoma, Diabetes, High Blood Pressure, Heart Disease, Lungs, etc.)

Have you had a MRSA infection? Yes No When? Still Active? Yes No

List all **Surgeries** you have had (Cataract, Appendectomy, Gall Bladder, Facial, Spinal, etc.) and DATE

Do you CURRENTLY have any problems in the following areas? ***(Please indicate NO or YES)***		NO	YES	DETAILS
Eye	(poor vision, fluctuating vision, eye pain, tearing, redness, itching, burning)			
General / Constitutional	(fever, heat stroke, weight loss or gain, unusually tired)			
Ears, Nose & Throat	(hard of hearing, stuffy nose, earache, cough, dry mouth)			
Cardiovascular	(stroke, high blood pressure, heart disease, racing pulse)			
Respiratory	(congestion, difficulty breathing, wheezing)			
Gastrointestinal	(diarrhea, constipation, ulcers)			
Genital, Kidney, Bladder	(painful or frequent urination, impotence, yellow jaundice)			
Muscles, Bones or Joints	(joint pain, stiffness, swelling, cramps arthritis, etc.)			
Skin	(pimples, growths, warts, rash, rosacea, etc.)			
Neurological	(headache, numbness, seizures, paralysis, etc.)			
Psychiatric	(anxiety, depression, insomnia, etc.)			
Endocrine	(diabetes, thyroid disorder)			
Blood/lymph	(high cholesterol, bleeding, anemia, clotting problems, problems related to blood transfusions)			
Allergic/Immunologic	(sneezing, swelling, redness, itching hives, lupus, etc.)			
Female	(pregnancy, nursing)			

Social History

Current Occupation:_____ Hobbies:_____

Previous Occupation (if Retired) _____

Does your vision limit any activities of daily living?

(employment, driving, reading computer work, sports, etc.) ☐ **NO** ☐**YES,** please explain:

_____

_____

_____

Do you drink alcohol? ☐**NO** ☐**YES** If YES, how much?_____

Do you use tobacco products? ☐**NO** ☐**YES** If YES, how much?_____
for how many years? .....

Have you ever had a blood Transfusion? ☐**NO** ☐**YES**

Family History

Please indicate if you have Blood Relatives with the following conditions:

	Unknown	**NO**	**YES**	**Indicate relation** (Mother, Father, Grand Parent, Sibling)
Blindness				
Cataracts				
Macular Degeneration				
Glaucoma				
Diabetes				
High Blood Pressure				
Heart Disease				
Stroke				
Cancer				
Thyroid Disorder				
Arthritis				
Lupus				

Additional Comments:

_____ _____

DATE

MEDICATION LIST

PLEASE COMPLETE THE FOLLOWING QUESTIONS AND BRING THIS WITHYOU TO YOUR NEXT OFFICE VISIT

Name:_____Date:_____

Are you diabetic? Yes ☐ No ☐ Do you use insulin? Yes ☐ No ☐

Are you allergic to:

Penicillin? Yes ☐ No ☐ Reaction: _____
Latex? Yes ☐ No ☐ Reaction: _____
Betadine? Yes ☐ No ☐ Reaction: _____
Shellfish? Yes ☐ No ☐ Reaction: _____

Have you ever taken Flomax (Tamsulosin) or Proscar? Yes ☐ No ☐

Are you allergic to any medications? Yes ☐ No ☐ (If yes, please list below).

Medication allergy	Reaction

List **all** medications you are **currently** taking (Prescriptions, over the counter, vitamins, herbals)
Refer to your medication bottles if necessary.

Name of Medication	Strength	Dosage taken	How often taken	Oral Inhaled Injection

If you need more space, please continue on the back of this sheet.

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>bothersome</u> 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

Name of eye drops/ointments and usage: _____

_____

For office use only:

SPEEDscore:

tOSM:____/____