ICON EYECARE
GRAND JUNCTION

-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:

ICON EYECARE

NAME: _____

DATE: _____

OCULAR SURFACE EVALUATION QUESTIONNAIRE

WHAT IS YOUR **MOST** BOTHERSOME SYMPTOM? _____

WHEN DID IT START? _____

Has it worsened recently? YES NO

HOW OFTEN? Occasionally Most Days Constant

HOW BOTHERSOME IS IT **ON A SCALE OF 1 - 10?**

1 5 10

Very Mild Debilitating

WHAT IS YOUR **SECOND MOST** BOTHERSOME SYMPTOM? _____

WHEN DID IT START? _____

Has it worsened recently? YES NO

HOW OFTEN? Occasionally Most Days Constant

HOW BOTHERSOME IS IT **ON A SCALE OF 1 - 10?**

1 5 10

Very Mild Debilitating

OTHER SYMPTOMS: _____

OTHER SYMPTOMS
(circle all that apply)

Itchy eyes | Congestion or other sinus issues | Runny nose or sneezing | Dark circle under your eyes

Swollen, puffy lids | Flaky or itchy skin | Dry mouth | Touching/ rubbing eyes | Snoring

WHAT HAVE YOU TRIED?
(circle all that apply)

OTC artificial tears | Hot compress | Restasis / Xiidra

Punctal Plugs | Steroid Drops | Other _____

EYE SURGERIES
(circle all that apply)

LASIK | PRK | RK | Retinal surgeries | Other _____

Tear duct surgery | Eyelid bump removal | lid lift | skin biopsy near eyes

ICON EYECARE

OCULAR SURFACE EVALUATION QUESTIONNAIRE (CONT.)

OTHER MEDICAL HISTORY
(circle all that apply)

Asthma Eczema Uticaria (hives) Diabetes Migraine

Thyroid dysfunction Rheumatoid Arthritis Fibromyalgia Lupus

Other autoimmune disease: _____

Allergies: (circle) Pollen Pets Indoor Food Radiation Chemotherapy

Other _____ Bone marrow transplant

Seasonal / Year round

Do you wear contact lenses? **Yes** **No**

OTHER MEDICATIONS
(circle all that apply)

Allergy pills (Zyrtec, Claritin, etc.) Nasal Spray Antidepressants

Blood pressure medications Hormone Replacement Therapy

Have you ever used Accutane? **Yes** **No**

COSMETIC/ MAKEUP USE

☐ Most days ☐ Infrequently ☐ Never

How do you clean your makeup off at night?

☐ Wash face
☐ Use makeup removing wipes
☐ Other _____

OTHER SOCIAL HISTORY

Work / Hobbies _____

QUESTIONS YOU WOULD LIKE THE DOCTOR TO ANSWER:

_____

_____

_____

OTHER TREATMENT PREFERENCES TO DISCUSS:

_____

_____

_____