Today's Date: _____

Patient's Name: _____ ☐ Male ☐ Female
Last First Middle

Address _____ Date of birth: _____
City _____ State _____ Zip _____ SSN: _____
Home phone ( ) _____ Work phone ( ) _____ Cell phone ( ) _____
Employer _____ Occupation _____ Marital Status _____

Emergency contact _____ Phone ( ) _____

INSURANCE INFORMATION

- Please present all medical insurance cards at time of check-in for your appointment.
- If you do not have insurance coverage, payment is due on the date of service.
- If you have a work-related injury, you must provide us with the L&I claim number.
- **Routine vision exams are often provided through a vision plan that is separate from your medical plan and may have a different provider network. Please check your routine vision benefit.**

PREFERRED PHARMACY:

_____ _____ ( ) _____
Pharmacy Address/City Phone

DID A HEALTH CARE PROVIDER REFER YOU FOR THIS VISIT? ☐ Yes ☐ No
If yes, name of clinician and clinic: _____

PRIMARY CARE PHYSICIAN _____ Phone ( ) _____

LIST YOUR CURRENT MEDICATIONS (include doses and frequency)

_____
_____
_____
_____
_____

☐ **Check here if you do not currently take any medications**

MEDICATION ALLERGIES

_____
_____
_____
_____
_____

☐ **Check here if no medication allergies**

INJURY INFORMATION

Is your visit related to an injury? ☐ Yes ☐ No Date of injury: _____ ☐ Right eye ☐ Left eye ☐ Both
Place of injury: ☐ Home ☐ Work ☐ Other (please specify): _____
If related to work injury: Employer at time of injury: _____ Phone: ( ) _____
Has your employer been notified? ☐ Yes ☐ No Has Claim been filed? ☐ Yes ☐ No Claim No. _____

EvergreenHealth Kirkland, WA 98034

PATIENT HEALTH QUESTIONNAIRE

FORM ID EYE 120
Approved 09/17

APPLY PATIENT LABEL HERE

YOUR PERSONAL OCULAR HISTORY:

☐ Prescription glasses (how old is prescription? ____ years) ☐ Readers (power: _____) ☐ Contact lens wearer

☐ Cataract ☐ Glaucoma ☐ Glaucoma suspect ☐ Diabetic retinopathy

☐ Crossed eye (strabismus) ☐ Patching one eye as a child ☐ Amblyopia ☐ Corneal disorder

☐ Retinal tear or detachment ☐ Macular degeneration ☐ Eye injury ☐ Eyelid disorder

☐ Other: _____

☐ Prior ocular or eyelid surgery(ies): _____ (include which eye and year)

FAMILY OCULAR HISTORY (*patient's biological mother, father, siblings and grandparents)*:

☐ Cataract(s) ☐ Glaucoma ☐ Glaucoma suspect

☐ Crossed eye (strabismus) ☐ Macular degeneration ☐ Retinal tear or detachment

☐ Corneal disease ☐ Other: _____

YOUR PERSONAL MEDICAL HISTORY (check all that apply)

☐ Diabetes (year diagnosed _____ , blood sugars range _____ , last HbA1C if known _____)

☐ High cholesterol ☐ High blood pressure ☐ Coronary artery disease ☐ Other heart problems: _____

☐ Stroke or TIA ☐ Asthma ☐ COPD/emphysema ☐ Arthritis

☐ Thyroid disease ☐ HIV/AIDS ☐ Hay fever/allergies ☐ Eczema/dry skin ☐ Autoimmune disease

☐ Sinus disease ☐ Cancer (please specify): _____

☐ Other medical history: _____

☐ Previous surgeries or hospitalizations (and year): _____

_____

SOCIAL HISTORY:

Do you smoke cigarettes (or cigars)? ☐ Yes ☐ No If yes, how many years: _____ How many packs per day: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks a week: _____ Do you chew tobacco? ☐ Yes ☐ No

REVIEW OF SYSTEMS – Do you *CURRENTLY OR RECENTLY* experience(d) any of the following:

Please circle specific problems below	YES	NO	If yes, **please explain**:
General (i.e. fever, unexpected weight loss/gain, night sweats or fatigue	☐	☐	_____
Ear/nose/throat (i.e. hearing loss, infections, sore throat, sinusitis)	☐	☐	_____
Cardiac (i.e. chest pain, irregular heartbeat, palpitations)	☐	☐	_____
Respiratory (i.e. shortness of breath, wheezing or cough)	☐	☐	_____
Hay fever or seasonal allergies	☐	☐	_____
Gastrointestinal (i.e. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary or genital (i.e. pain with urination, frequency, blood in urine)	☐	☐	_____
Skin (i.e. rashes, dryness, rosacea, acne, non-healing sores, moles)	☐	☐	_____
Musculoskeletal (i.e. back pain, muscle aches, joint pain or swelling)	☐	☐	_____
Neurological (i.e. numbness, weakness, slurred speech, headaches, seizures)	☐	☐	_____
Endocrine (i.e. frequent urination, excessive thirst, missed periods, heat or cold intolerance, unexplained lactation, hot flashes)	☐	☐	_____
Psychiatric (i.e. depression, sadness, mania, hallucinations, anxiety)	☐	☐	_____

► Patient signature_____ Date: _____**

*** If someone other than the patient completed this form, please write your name and relationship to the patient:*

Name: _____ Relationship: _____ Date: _____

APPLY PATIENT LABEL HERE