Newberg Vision Clinic, P.C.

(Some insurance companies require answers to the following questions. Please complete the following questionnaire as accurately as possible. Your answers are important and will help us serve you better. All responses are kept confidential.)

Patient's name____ Age______

Ethnicity: American Indian-Alaska Native-Asian-Black/African American-Hispanic-Native Hawaiian-other Pacific Island- White

Communication preference email_____ postal_____ telephone_____

Primary reason for visit today? Cataract___ Glaucoma___ Diabetes___ Routine Eye Exam___ Other___

Do you currently wear glasses? ___Yes ___No Contact lenses? ___Yes ___No If yes, what type?________________________

If you are a new patient, when was your last eye exam?_________________ Doctor or location_________________________

How did you hear about our clinic? ___telephone book ___family member Referred by ____________________________

When was your last medical or physical exam?_____________ Doctor's name____________________________________

What is your occupation or grade level and school if you are a student?____

Do you experience any of the following? ___headaches ___double vision ___dry eyes ___eyestrain

Do you experience, or have you had, any of the following:

Blurred vision without glasses or contact lenses ___Yes ___No
If yes, in the distance, near, or both (circle)
Blurred vision while wearing your glasses or contact lenses ___Yes ___No
If yes, in the distance, near, or both (circle)
Eye injuries ___Yes ___No If yes, please list:____
Eye surgeries ___Yes ___No If yes, please list:____

Do you have allergies? ___Yes ___No Allergic to what?_________________ What happens?________________________

Do you use cigarettes/tobacco?___________ Alcohol?__________ Other substances?__________

Do you or any of your family members have any of the following conditions?

	SELF	FAMILY MEMBER
Asthma	Yes___	Yes___Relationship:_______________
Diabetes	Yes___	Yes___Relationship:_______________
High blood pressure	Yes___	Yes___Relationship:_______________
Heart conditions	Yes___	Yes___Relationship:_______________
Glaucoma	Yes___	Yes___Relationship:_______________
Cataracts	Yes___	Yes___Relationship:_______________
Macular degeneration	Yes___	Yes___Relationship:_______________
Amblyiopia (lazy eye)	Yes___	Yes___Relationship:_______________

Other conditions: (please describe)

Do you currently take any medications (prescription or over the counter)? ___Yes ___No If yes, please list: _______________

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Ladies, are you currently pregnant? ___Yes ___No or are you a nursing mother? ___Yes ___No

____ _____________________ Dr. initials_______
Patient Signature Date