McMinnville Family Eye Care
2185 NW 2nd St. Suite B, McMinnville, OR 97128
503.435.1231

PATIENT INFORMATION

Name _____ Date of Birth ___/___/_____ Age____
Preferred Name (if different than above)_____ Gender M / F
Address _____
City_____ State_____ Zip _____
Phone _____ Email _____
Occupation & Employer _____
Hobbies/Activities outside of work _____
Name of Parent/Guardian if under 18 _____ Date of Birth ___/___/_____
Primary Care Physician _____ Clinic _____
Last Eye Exam _____ Last Medical Exam _____
Who should we contact in case of an emergency?
Name: _____ Phone #_____

Is it OK to leave a message? ❑ Yes ❑ No

THANK YOU FOR COMING IN

How did you hear about our office? Please check all that apply: ____Insurance
____MFEC website/Facebook ____Insurance website ____Mac Chamber of Commerce
____Personal Referral, name _____ ____Other, _____

CORRECTIVE LENS HISTORY

Do you wear glasses? ☐ Yes ☐ No
If yes, what type? ___Single Vision ___Progressive ___Bifocal ___Trifocal
Do you wear contacts? ☐ Yes ☐ No
If yes, what type? ___Soft ___Rigid Gas Perm
How often do you replace them? ___ 2 weeks ___1 month ___ Other:_____
Do you sleep in your lenses? ___ every night ___ occasionally ___never

MEDICAL HISTORY

Please list any medications you take: _____
_____
Please list any medication allergies: _____
Do you have any of the following?
___Blurry Vision ___Eye Strain ___Eye Pain / Headaches
___Sandy / Gritty Eyes ___Watery Eyes ___Itchy Eyes
___Glaucoma ___Diabetic Retinopathy ___Macular Degeneration
Does anyone in your **family** have a history of the following?
___Diabetes ___Glaucoma ___Macular Degeneration
Do you use any of the following on a regular basis?
___Alcohol ___Tobacco ___Recreational Drugs

Do you currently have any problems in the following areas? If "yes" please explain:

	YES	NO	
General Constitution (Fever, weight loss, other)	❑	❑	_____
Ears, Nose, Throat (cold, sinus, cough)	❑	❑	_____
Cardiovascular (heart, vessels, etc)	❑	❑	_____
Respiratory (asthma, emphysema)	❑	❑	_____
Gastrointestinal (ulcers, intestinal disease)	❑	❑	_____
Genital (kidney disease, bladder)	❑	❑	_____
Skin (rosacea, skin cancer)	❑	❑	_____
Neurological (MS, stroke, seizures)	❑	❑	_____
Psychiatric (anxiety, depression)	❑	❑	_____
Endocrine (diabetes, thyroid)	❑	❑	_____
Blood / Lymph (high cholesterol, anemia)	❑	❑	_____
Allergy/Immunologic (hay fever, lupus)	❑	❑	_____

Women: Are you pregnant or nursing? ___Yes ___No

Please notify us at least 24 hours in advance if you need to change your appointment.

Please read and sign below:

- I acknowledge that I understand the Notice of Privacy Practices for the office of McMinnville Family Eye Care. (Copy available upon request)
- I authorize the release of any medical information necessary to process my insurance claims.
- I authorize payments of insurance benefits directly to McMinnville Family Eye Care for services received in this office.
- I understand that I am financially responsible for all fees incurred for services rendered which are not paid by my insurance.

SIGNATURE _____ **DATE**_____

Patient (or legal representative) signature required prior to any services being rendered.