

GRESHAM VISION CENTER
125 NW MILLER
GRESHAM, OR 97030
503-665-3813

SANDY VISION CENTER
39400 PIONEER BLVD STE 3
SANDY, OR 97055
503-668-4313

www.greshamvisioncenter.com

WELCOME TO OUR OFFICE

Name _____

Today's date _____ Date of last exam _____

Street _____

Date of birth _____ Age _____ Sex: M F

City _____ State _____ Zip _____

Spouse(or parent) _____

Home phone _____ Work phone _____

Spouse/Parent phone _____

Employer _____

Vision Ins _____

Occupation _____

Subscriber ID _____

Name of Insured _____

Medical Ins _____

Insured date of birth _____

Subscriber ID _____

Hobbies _____

Email address _____

How will you settle your account balance today?

- Cash Check
 Debit Card Credit Card(Visa/MC/Discover)

Reason for today's visit?

Are you planning on replacing your glasses today?	NO	YES	Do you experience...		
Do you have more than once pair of current Rx glasses?	NO	YES	Any discomfort with your eyes?	NO	YES
Do you work on a computer for long periods?	NO	YES	Problems with glare, reflection, night driving?	NO	YES
If you wear glasses, would you benefit from thinner/lighter lenses?	NO	YES	Sensitivity to light?	NO	YES
Do you spend a lot of time outdoors?	NO	YES	Headaches?	NO	YES
If you wear bifocals, are you bothered by lines or head tilting?	NO	YES	Floater or flashes of light?	NO	YES
Are there times you'd rather not wear glasses?	NO	YES	Other _____		
If you wear contact lenses, are you satisfied with vision and comfort?	NO	YES	_____		
Are you interested in a "test drive" of the latest in contact lens design(s)?	NO	YES	_____		
Are you interested in laser vision correction?	NO	YES			

MEDICAL HISTORY

	SELF		FAMILY		SELF		FAMILY
Allergies	NO	YES	YES	Glaucoma	NO	YES	YES
Asthma	NO	YES	YES	Eye diseases	NO	YES	YES
Arthritis	NO	YES	YES	Heart disease	NO	YES	YES
Cancer	NO	YES	YES	Eye injury	NO	YES	YES
Eye surgery	NO	YES	YES	Diabetes	NO	YES	YES
High BP	NO	YES	YES	Thyroid	NO	YES	YES

Any significant health changes in the last year? _____

Current Medications (Rx and over the counter)

Are you allergic to any medications? _____

Name of Medication

Diabetic Meds	NO	YES	_____
Blood Pressure	NO	YES	_____
Cholesterol	NO	YES	_____
Allergy/Asthma	NO	YES	_____
Hormone/Birth Control	NO	YES	_____
Psychiatric	NO	YES	_____

Other _____

Name of primary care physician/clinic _____

Phone _____

Who may we thank for referring you to our office?

Family member _____

Phone book or ad

Coworker or friend _____

Insurance list

Doctor _____

Live/work nearby

Oregon Optometric Association

Other _____