Downtown Vision Centre
Linda R. Medeski, O.D.
Robert A. Nicacio, O.D.
912 Main Street
Vancouver, WA 98660
(360) 694-6541 phone
(360) 696-2578 fax

Patient Name: _____ Nickname:_____

Birth Date: ____ / ____ / ____ **SSN#**: _____ - ____ - _____ **Sex**: ☐Male ☐Female

Address: _____

City/State: _____ **Zip**: _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Please call me at: ☐Home ☐Work ☐Cell **E-Mail Address**: _____

Best reached by: ☐Phone ☐Mail ☐Email ☐Text **Parent's name if patient is a minor**:_____

Employer/School: _____ **Occupation**: _____

Approx. Date of Last Eye Exam: _____ Eye Doctor's Name: _____

Emergency Contact: _____**Phone** #: _____ **Relationship**: _____

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed **Spouse's Name**:_____

Preferred Language: ☐English ☐Russian ☐Spanish ☐Other:_____

Ethnic Origin: ☐Hispanic ☐Caucasian ☐African American ☐Native American ☐Asian ☐Pacific Islander ☐Other:_____

Employment: ☐Full Time ☐Part Time ☐Retired ☐Unemployed **School**: ☐Full Time ☐Part Time ☐Not A Student

Referred to our office by: ☐Physician ☐Phone Book ☐Advertisement ☐Insurance ☐Friend:_____ ☐Other:_____

Person responsible for payment, if other than above

Name: _____ Birth Date: _____ / _____ / _____ Sex: ☐M ☐F

Address: _____ SSN#: _____ - _____ - _____

City/State: _____Zip:_____ Employer: _____

Relationship: _____ Occupation: _____

Home Phone: _____ Work: _____ Cell Phone: _____

Insurance Information: **We require a photocopy of your current insurance cards for our records every month**

VISION Insurance: _____ **SECONDARY VISION**: _____

Subscriber Name: _____ Subscriber Name: _____

Birth Date: _____ / _____ / _____ Sex: ☐M ☐F Birth Date: _____ / _____ / _____ Sex: ☐M ☐F

ID#: _____ ID#: _____

MEDICAL Insurance: _____ **SECONDARY MEDICAL**: _____

Subscriber Name: _____ Subscriber Name: _____

Birth Date: _____ / _____ / _____ Sex: ☐M ☐F Birth Date: _____ / _____ / _____ Sex: ☐M ☐F

ID#: _____ ID#: _____

Please mark the visual tasks and activities in which you participate.

☐ Screen Time 0-2 hours per day
☐ Screen Time 2-4 hours per day
☐ Screen Time 4-6 hours per day
☐ Screen Time 6-8 hours per day
☐ Screen Time >8 hours per day

☐ Sports _____
☐ Outdoor Activities / Winter / Summer
☐ Water Activities
☐ Extensive Near Work
☐ Carpentry/Mechanics
☐ Operating Machines

OVER 

Primary Care Doctor: _____ City/State:_____ Phone #_____

Pharmacy: _____ Location:_____ Phone#_____

Medications: List medications you are currently taking, including eye drops and supplements _____

_____

_____

_____

_____

☐ See List ☐ None

Allergies: List allergies to medications or other substances

_____

_____

_____

_____

_____

☐ See List ☐ None

Personal Medical History: Please circle all that apply-past or present.

Asthma	Heart Problems	HIV	MS	Shingles
Arthritis	Head Injury	Liver Disease	Myasthenia Gravis	Skin Problems
Cancer	High Cholesterol	Lupus	Pregnancy week# ____	Stroke
Diabetes	High Blood Pressure	Kidney Disease	Pre-Diabetes	Tuberculosis
Fainting	Hepatitis	Lung Disease	Seizures	Thyroid Disease
				Other: _____

Personal Habits:

Do you smoke? ☐ Yes ☐ No If yes, for how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Personal Eye Health History: Circle all that apply

Vision Insurance	***Medical Insurance: Deductible, Coinsurance, Copay may apply.***			
Blurred Vision Distance	Bloodshot Eyes	Dry Eyes	Headaches	Seeing Halos
Blurred Vision Near	Burning Eyes	Eye Infection	Itching Eyes	Seeing Flashes
Double Vision	Cataracts	Eye Injury	Light Sensitivity	Twitching Eyelids
Eye Strain	Color Vision, Poor	Eye Strain	Loss of Vision	Watering Eyes
Night Vision, Poor	Crossed Eyes	Floaters or Spots	Macular Degeneration	Other: _____
	Diabetic Eye Problems	Glare Problems	Migraine Headaches	
	Double Vision	Glaucoma	Temporary Loss of Vision	

Eye Surgery:

Cataract Surgery (Date of Surgery) Right: _____ Left: _____

Refractive Surgery Type: _____ (Date) Right: _____ Left: _____

Other: _____ Date of Surgery: _____

Family Health History: Please circle yes or no ***and*** the relationship to patient.

Eye Disease	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Tuberculosis	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Blindness	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Cancer	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart Disease	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Diabetes	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Glaucoma	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
High Blood Pressure	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Retinal Detachment	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Macular Degeneration	Yes	No	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent

Signature: _____ **Date:** _____

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated:_____ Updated:_____