North Woods Optics

20 N Lake Street Suite 101 * Forest Lake, MN 55025 * 651-464-4824

Personal Information

Last Name: _____ First Name: _____ Birth Date: _____

Address: _____ City: _____ State:_____ Zip: _____

Primary Phone #:_____ Secondary Phone #: _____

Optional: American Indian or Alaska Native | Asian | Black or African American | Hispanic | Native Hawaiian/Other Pacific Islander | White

Employment Status: Full-Time Part-Time Unemployed Occupation: _____

Employer: _____ Social Security Number _____

Insurance Carrier: _____ Policy Holder Name: _____

Policy Holder Date of Birth _____ Policy Holder Social Security Number _____

Primary Care Physician_____ Name of Clinic_____

Clinic Phone Number _____ Clinic Fax Number _____

Patient Medical History

Have you experienced any problems in the following areas? If so, please provide additional information.

Condition	Yes	No	Description
Cardiovascular *(High Blood Pressure, Cholesterol, etc.)*			
Ears, Nose, Throat *(Earache, Sinusitis, etc.)*			
Endocrine *(Diabetes, Thyroid, etc.)*			
Gastrointestinal *(Ulcers, etc.)*			
General *(Fever, Weight Loss or Gain, Tired, etc.)*			
Muscles, Bones, Joints *(Joint Pain, Arthritis, etc.)*			
Neurological *(Numbness, Headaches, etc.)*			
Psychiatric *(Anxiety, Depression, etc.)*			
Respiratory *(Asthma, Sleep Apnea)*			
Skin *(Growths, Rash, etc.)*			
Uro-Genital *(Kidney, Bladder, Painful Urination, etc.)*			

Patient Ocular History

Do you experience any of the following problem? If so, please provide additional information.

Condition	Yes	No	Description
Blurred Vision			
Color Blindness			
Crossed or Lazy Eye			
Double Vision/Loss of Side Vision			
Dryness/Gritty Feeling/Redness/Tearing			
Eye Diseases Previously Diagnosed *(i.e. Cataract, Glaucoma, etc)*			
Eye Pain/Irritation			
Flashes of Light/Floating Objects			
Glare or Light Sensitivity			
Recent Infections			
Previous Eye Injury			
Previous Eye Surgery			

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Medication(s) Used

*If you brought a list of your medications we can copy it for your convenience.

SYSTEMIC

_____

_____

_____

_____

OCULAR

_____

_____

_____

_____

Allergies

_____ _____

_____ _____

Medication Allergies

_____ _____

_____ _____

Family History: Ocular & Medical

*Please indicate relationship to you and the specific condition

	Condition	Yes	No	Family Member	Description
Eye:	Blindness				
	Color Blindness				
	Crossed or Lazy Eye				
	Cataract				
	Glaucoma				
	Macular Degeneration/ Retinal Detachment				
	Other				
Medical:	Arthritis				
	Cancer				
	Diabetes				
	Genetic Disorders				
	Heart Disease/ Hypertension/Stroke				
	Kidney Disease				
	Thyroid Disease				
	Other				

Do you smoke? Yes___ No ___ If Yes, how many packs per day? ____

Do you drink alcohol? Yes___ No ___ If Yes, how many times per week? ____

Patient's Signature: _____Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Doctor's Signature: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____