Dr. Pamela S. Fraser – 877 NE 25th Ave., Hillsboro, OR 97124 – (503) 648-5236

FIND US ON FACEBOOK! http://www.facebook.com/PamelaFraserOD

WELCOME!

Thank you for choosing us for your eye care needs.

Please take a few minutes to fill out this form to the best of your ability. If you have any questions we will be glad to help. ☺

PATIENT INFORMATION

Patient Name ______________________________ **Birth Date** ____________ **Sex** **M** **F**

Address ______________________________ **City**______________ **State**________ **Zip** __________

Phone (home) ______________ **(work)** ______________ **(cell)** ______________

Social Security # ______________ **Emergency Contact** ______________ **Phone** ____________

Race (CIRCLE ONE) Alaska Native Asian Black/African American Caucasian / White Native Hawaiian / Pacific Islander Native American Other ______________ Refuse to Specify

Ethnicity (CIRCLE ONE) Hispanic / Latino Non-Hispanic / Latino Unknown Refuse to Specify

Patient Status (CIRCLE ONE) Single Married Divorced Widowed Other

Email ______________________________ **Preferred Language (other than English)** ______________

Employer ______________________________ **Occupation** ______________________________

How Did You Hear About Us? Interent Insurance Listing Advertisement Drive By School/Work Doctor

Family/Friend Referral ______________________________

INSURANCE INFORMATION

Who is responsible for this account? ______________________________ **Relationship** ______________

Insurance Company ______________________ **ID#** ______________________ **Group #** ______________

Subscriber Name ______________________ **Subscriber Birth Date** ____________ **Subscriber SSN#** ____________

Relationship to patient ______________ **Is patient covered by other insurance?** **YES**☐ **NO** ☐

EYE HEALTH HISTORY

Date of Last Eye Exam __________ **Location / Doctor Name (if not here)** ______________________________

Do you wear glasses? NO YES, PART TIME YES, FULL TIME

Do you wear contact lenses? NO YES IF YES... Type ____________ Hours/Day ________ Solution ____________

****Please mark to indicate if you have ever had any of the following:**

	YES		**YES**		**YES**
Blurred Vision		**Chronic Eye Infections**		**Dry Eyes**	
Eye Injury / Head injury		**Eye Strain**		**Fainting/Blackouts**	
Flashes		**Floaters/Spots**		**Halos**	
Headaches/Migraines		**Itchy Eyes**		**Light Sensitivity**	
Loss of Vision		**Poor Night Vision**		**Watering Eyes**	

HEALTH HISTORY

Primary Physician Name ______________________________ **Date Last Seen** ____________

Are you using *any* medications, either prescription or otherwise? NO YES

IF YES... Please list ____

____

Vitamins or Supplements? ____

Are you allergic to any medications? NO YES, ____

IF YES... Please list ____

****Please mark to indicate if you have ever had any of the following. Also place a mark to indicate if a *blood relative* has had any of the following health problems.**

	SELF	**FAMILY**	**RELATIONSHIP**
Eye Disease **(ex: glaucoma, macular degeneration, retinal disease, blindness)**			
Eye Condition **(ex: strabismus / eye turn, amblyopia / lazy eye, poor color vision)**			
Eye Surgery **(ex: cataracts, retinal detachment, LASIK / PRK, ptyergium, blepharoplasty)**			
Ear/Nose/Throat Condition **(ex: vertigo, tinnitus, chronic sinusitis)**			
Cardiovascular Disease **(ex: high blood pressure, cholesterol, heart disease, heart attack, stroke)**			
Respiratory Condition **(ex: asthma, COPD, emphysema)**			
Musculoskeletal Condition **(ex: arthritis, osteoporosis, bone/joint condition, muscle condition)**			
Skin Condition **(ex: rosacea, eczema, psoriasis, hives, rashes)**			
Neurological Disorder **(ex: headache, migraines, epilepsy, seizures, sleep disorder, paralysis, dementia)**			
Psychiatric Disorder **(ex: depression, chemical dependency, anxiety disorder)**			
Endocrine Disorder **(ex: thyroid, diabetes, malaise)**			
Blood / Lymph Disorder **(ex: AIDS/HIV, anemia, hepatitis)**			
Gastrointestional Disorder **(ex: esophageal reflux, IBS, digestive problems)**			
Genito-Urinary Disorder **(ex: kidney disease, incontinence)**			
Allergic/Immunological Condition **(ex: cancer, lupus, seasonal allergies, autoimmune disorders)**			
Constitutional **(weight loss, fever)**			
OTHER (____)			
Please list any surgeries you have had below:			

Do you smoke or use tobacco products? NO OCCASIONALLY ½ PACK PER DAY 1 PACK PER DAY 1+ PACK PER DAY CHEWING

Do you drink alcohol? NO OCCASIONALLY 1 PER DAY 2-3 PER DAY 4+ PER DAY

Do you use illicit (illegal) drugs? NO YES, TYPE AND FREQUENCY ____

Do you engage in regular exercise? YES NO

Are you pregnant or breast-feeding? YES NO

Hobbies/Interests ____

Patient Name: ____ **Date:** ________________________

Signature of Patient or Guardian: ____