Maple Valley Vision Clinic

Wilderness Village 23714 222nd PL SE Ste B, Maple Valley, WA 98038
Phone **425-432-1206** / Fax **425-413-4465**

Today's Date: ____________________________

Patient Information

Last Name ______________________________

First Name ____________________ MI _______

Date of Birth ______________________________

Sex ☐ Male ☐ Female ☐ Other

Last 4 of SSN __________________________

Address ________________________________

City _______________ State ____ Zip_______

Home/Cell # ________________________
____
____

Email Address ___________________________

May we email or text you with appointment confirmations and/or recalls?

☐ Yes ☐ No

Spouse/Parent Name ____________________

Spouse/Parent Phone # ____________________

Insurance Information

Vision Insurance __________________________

Subscriber Name __________________________

Subscriber ID# __________________________

Subscriber DOB __________________________

Medical Insurance __________________________

Subscriber Name __________________________

Subscriber ID# __________________________

Subscriber DOB __________________________

PLEASE BE ADVISED if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Maple Valley Vision Clinic.

If your insurance company has not reimbursed our office in full within 90 days, we will request payment from you and your insurance company will then need to pay you directly.

Signature _________________________________

Thank you for choosing our office!

How did you hear about us?

☐ Friend/Relative ________________________
☐ Insurance Company
☐ Web page / Social Media
☐ Saw Building/Sign
☐ Other ________________________________

Do you have any family members that need vision services?

☐ Yes ☐ No

The information in this confidential case history form is critical to the evaluation of your vision and health.

Name of family physician :____________________
Date of last physical check-up: ____________________

Medications (Prescription and Over-the-counter)
Allergies to medications? ☐ Yes ☐ No
If yes, which medications? ____________________

List the names of **current** medications, including eye drops, vitamins & birth control pills: ____________________

Have you ever been diagnosed or treated for any of the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Cancer	☐	☐
Cholesterol (elevated)	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Skin Conditions	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Thyroid	☐	☐
Unusual Weight Loss/Gain	☐	☐
Do you use tobacco?	☐	☐
If not now, have you ever used tobacco in the past?	☐	☐
Are you currently pregnant?	☐	☐

Is there a family history of any of the following?

		Relationship
Blindness	☐	__________
Corneal Problems	☐	__________
Diabetes	☐	__________
Glaucoma	☐	__________
Heart Disease	☐	__________
Lazy Eye	☐	__________
Macular Degeneration	☐	__________
Retinal Problems	☐	__________

What is the major purpose of this visit?
____

Date of your last eye exam: ____________________

Have you ever experienced, been diagnosed with, or been treated for any of the following?

- ☐ Blurry Vision
- ☐ Burning
- ☐ Crossed Eye/ Eye Turn
- ☐ Double Vision
- ☐ Flashes of Light
- ☐ Floaters/Spots
- ☐ Glaucoma
- ☐ Grittiness
- ☐ Headaches
- ☐ Itchiness
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Sunlight Sensitivity
- ☐ Trouble seeing at night
- ☐ Uncomfortable Glasses
- ☐ Watery Eyes
- ☐ Other eye disorders ____________________

Have you ever had any accidents, injuries or surgeries (i.e. Lasik, Cataract, etc.) to your eyes or head?

If yes, please list ____________________

Do you currently wear glasses?	☐ Yes	☐ No
Do you currently wear contact lenses?	☐ Yes	☐ No
If yes, are you satisfied with the vision and comfort of your contact lenses?	☐ Yes	☐ No
If no, are you interested in trying contact lenses?	☐ Yes	☐ No

Additional information

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