



Dr. Mari L. Ward

21887 SW Sherwood Blvd Suite B, Sherwood OR 97140
Phone: 503-625-5599

NEW Patient Information (All information will be Confidential)

Patient Today's Date Date of Birth

Reason for today's visit

Address

City/State/Zip

Phone: Day Evening E-mail address

Parent/Guardian (if patient is a child)

Address/Phone (if different)

Visual Information

Date of last vision exam Referring or last Doctor

Please check all that you are experiencing with your current correction:

Yes

- Blur far away
Blur up close
Headaches
Squinting
Night vision problems
Frequent loss of place
Reading held at 10" or less

Yes

- Eyes itch
Eyes water easily
Dry eyes
Sleepy w/reading
Floaters or spots
Eyes burn
Double vision when reading

Yes

- Discharge from eyes
Light sensitivity
Motion sickness reading in car
Nausea or stomach problems
Pain in or around eyes
Eye strain/tired eyes

Have you had any eye injury, infection or surgery? yes no

Explain

Insurance Information

S. S. # Employer Name

Vision Insurance Co. Major Medical Insurance Co.

Name of insured Name of insured

Policy/Group # Policy/Group #

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? yes no

If so, please complete the following:

Name of insured Relationship to patient

Group # or Employer Name Insured S. S. #



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Health Information

Please list any medications you are taking and their purpose:

Have you had any significant changes in your health or any major health problems? yes no

Explain

Do you or does anyone in your family have a history of:

- Self Family High Blood Pressure Self Family Arthritis
Heart Disease Epilepsy
Stroke Cancer
Diabetes Hypoglycemia
Allergies/Hay Fever Glaucoma
Thyroid Problems Cataract
Eye Disease Strabismus (crossed or wall eyes)
Amblyopia (lazy eye)

Are you allergic to any medications? yes no Please list

Lifestyle Factors

Occupation Spouses' Occupation

Are you required to wear safety glasses at work? yes no

Do you work at a computer or video display terminal? yes no

What hobbies, social activities or sports do you participate in?

Are you tired of wearing glasses and interested in contacts? yes no

If you currently wear contacts, what brand and type are they? soft gas perm Brand

Are you interested in getting updated glasses? yes no

Do you have a back-up pair of glasses available? yes no

Do you have prescription sunglasses? yes no

Does road glare bother you? yes no

Whom may we thank for referring you to our office?

- Family/Friend Paper Yellow pages Web site Office sign Insurance listing

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X

Signature of Patient (Or parent if a minor)

Date

Doctor Initials/Date