ClarifEye Family Eyecare

Dr Robert Grigg
Dr Lisa Grigg

Our Commitment

to provide you with personalized quality eye care for life

Todays Date_____

Patient Name: _____

Mailing Address _____

City, State, Zip _____

Date of Birth: _____ Age: ____ Sex: M F

Cell Phone _____ Cell same as Home? Y / N

Home Phone _____ Daytime Phone _____

Social Security # _____

E-mail Address _____

Guarantor Information:

Name: _____

Mailing Address_____

Date of Birth _____ Relationship to Patient_____

Cell Phone _____ Cell same as Home? Y / N

Home Phone _____ Daytime Phone _____

Primary Insurance: _____

ID #: _____ Insured Party:_____

SSN:_____ DOB: _____

Secondary Insurance or Vision Insurance:_____

ID #: _____ Insured Party:_____

SSN:_____ DOB:_____ Relationship:_____

How did you first hear about our office?

☐ Internet / Facebook ☐ Kuna Area Phone Directory

☐ Kuna Melba News ☐ Street Signage

☐ Friend/Relative/Physician...Who?

VISUAL NEEDS

Do You..... (check the box if your answer is yes)

☐ Work at a computer for long periods of time?

☐ Spend a lot of time outdoors?

☐ Have sunglasses? Are they polarized? Yes or No

☐ Have or are you interested in lenses that automatically darken?

☐ Do you wear or are you interested in wearing contacts?

☐ Participate in sports / hobbies? What?

☐ Trouble seeing at night?

☐ Blurry distance/ near vision?

MEDICAL HISTORY

Family or General Physician's name: _____

Currently Taken Medications (Rx or Over-the-Counter) **YES** or **NO** (List)_____

_____

Allergic to any Medications? **YES** or **NO** (List) _____

Do you have any problems in the following areas?

(Please check **YES or NO** and **CIRCLE** and if "other" explain)

YES ☐ NO ☐ **Allergy**
(Hay Fever, Sulfa Drugs, Foods or other)

YES ☐ NO ☐ **Cardiovascular**
(High Blood Pressure, High Cholesterol or other)

YES ☐ NO ☐ **Constitutional**
(Constant Dizziness, Long-Term Fatigue or other)

YES ☐ NO ☐ **Endocrine**
(Diabetes, Hypothyroid, Hyperthyroid or other)

YES ☐ NO ☐ **Gastrointestinal**
(Stomach ulcers, Acid Reflux, or other)

YES ☐ NO ☐ **Genitourinary (Genitals, Kidney, Bladder)**
(STD's, Bladder Infections, Prostate or other)

YES ☐ NO ☐ **Ears, Nose, Mouth, Throat**
(Sinus Trouble, Ear Infections or other)

YES ☐ NO ☐ **Hematologic, Blood/Lymph**
(Anemia, Leukemia, Cancer or other)

YES ☐ NO ☐ **Immunologic**
(Lupus, Herpes, HIV, Sjogrens or other)

YES ☐ NO ☐ **Integumentary (Skin)**
(Acne, Warts, Skin Cancer or other)

YES ☐ NO ☐ **Musculoskeletal (Muscles, Bones, Joints)**
(Arthritis, Osteoporosis or other)

YES ☐ NO ☐ **Neurological**
(Multiple Sclerosis, Migraines or other)

YES ☐ NO ☐ **Psychiatric**
(Anxiety, Depression, Bipolar or other)

YES ☐ NO ☐ **Respiratory**
(Asthma, Emphysema, COPD or other)

FAMILY MEDICAL HISTORY

Relationship to you

☐ Glaucoma _____

☐ Macular Degeneration _____

☐ Diabetes ☐ High Cholesterol ☐ High Blood Pressure

☐ Other _____

SOCIAL HISTORY

Employer (or School) _____

Occupation (or Grade) _____

If 13 year old or older:

☐ YES ☐ NO Do you use tobacco products?

☐ YES ☐ NO Do you drink alcohol?

Welcome to *ClarifEye Family Eyecare*

We look forward to serving your vision and eye health care needs.