MARK R. HOVANDER, O.D.

UNIVERSITY VISION CLINIC, INC. 4115 University Way N.E. Suite 101 Seattle, WA 98105

Name ______________________ Date of Birth ____/____/____ Today's Date ____________

Address ______________________ City ____________ Zip ________

Parent's address or stable address if you are a student ______________________

Home Phone (   ) ____________ Work Phone (   ) ____________

Cell Phone (   ) ____________ Email Address ____________

Vision Insurance Company ____________ Medical Insurance Company ____________

Whom may we thank for recommending our office to you? ______________________

When was your last eye examination? ____________ How old are your glasses? ____________

What type of work do you do? ____________ Employer ____________

What special visual demands do you have at work or with hobbies? ______________________

Do you use a computer? **YES** **NO** If yes, on average, how many hours per day?____________

What is the reason for your examination today? ______________________

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING CONDITIONS?

YES	**NO**	Itching, Tearing, Burning, Secretions, Styes	**YES**	**NO**	Sudden loss of vision
YES	**NO**	Eyes tire when you read or use computer	**YES**	**NO**	Flashes of light
YES	**NO**	Frequent headaches/migraines	**YES**	**NO**	Floating spots in field of vision
YES	**NO**	Pain in your eyes	**YES**	**NO**	Periods of seeing double

Are you currently being treated for any eye conditions? **YES** **NO** Do you have a family history of eye disease or blindness? **YES** **NO**

Are you under care for any disease or medical condition at this time? **YES** **NO** If yes ____________

List of other doctors whom you are currently seeing and their specialty? ______________________

Do you or any family members have:

YES	**NO**	Diabetes	Who? ________
YES	**NO**	High blood pressure	Who? ________
YES	**NO**	Glaucoma	Who? ________
YES	**NO**	Macular Degeneration	Who? ________
YES	**NO**	Thyroid problems	Who? ________
YES	**NO**	Keratoconus	Who? ________

Do you have any of the following?

YES	**NO**	Drug sensitivities
YES	**NO**	Asthma
YES	**NO**	Allergies
YES	**NO**	Multiple Sclerosis
YES	**NO**	Do you use tobacco
YES	**NO**	Ever fainted while giving blood or at a Doctor's visit

When was your last physical examination? ________ The results? ______________________

Please list your current medications ______________________

If you wear contact lenses, please answer the following questions

What type are you currently wearing? **Soft** **Gas-Permeable** **Hard**

How old is your current pair of lenses? ________ How many years have you worn contacts? ________

What brand of cleaning/disinfecting solution are you currently using? ______________________

The average number of hours you wear the lenses per day? ________ Today? ________

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