McDonald Eye Care Associates
20094 Kenwood Trail, PO Box 847
Lakeville, MN 55044
Phone: (952)469-EYES(3937)
Fax: (952)469-2132
www.mcdonaldeyecare.com

McDonald Eye Care ASSOCIATES

Date:

Patient Name		**Gender:**	**Date of Birth:**	
Address:	Street: ______________________ City, State Zip: ______________________			
Medicare ID #		**Last 4 of Social Security #:**		

Communication							
Home Phone #[2]		**Work Phone #[2]**		**Extension**		**Cell Phone #[2]**	
____________	Please initial here AND circle the # if we are able to leave a detailed message, if necessary						
Email[2]	This allows us to e-mail your Continuity of Care Document (CCD) to your patient portal at the end of your visit[2]						
Employer:	This is important for insurance reasons						
If you wish to continue to receive BLUE Recall post-cards as reminders, please select U.S. Mail. **Selection of other methods does not guarantee we will communicate with you in that manner at this time.**							
Annual Exam: ☐ E-mail ☐ U.S. Mail	*Appointment:* ☐ E-mail ☐ Text ☐ Phone	*Glasses/Contacts:* ☐ E-mail ☐ Text ☐ Phone					

Information	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Other
Preferred Language[2]	
Race[2]	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer
Ethnicity[2]	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Answer

Emergency Contacts / Other Contacts		
Emergency Contact?	☐ Yes ☐ No	☐ Yes ☐ No
Release Medical Info	☐ Any ☐ Medical Info Only ☐ Financial Info Only	☐ Any ☐ Medical Info Only ☐ Financial Info Only
Salutation		
First Name		
MI		
Last Name		
Relation to Patient		
Home Phone #		
Work Phone #, EXT		
Cell Phone #		

Signature: ______________________________ (authorizing the release of specified information to the above contacts)

PATIENT HEALTH HISTORY INFORMATION

PLEASE REVIEW, MAKE NECESSARY CHANGES AND SUPPLY ANY MISSING INFORMATION

Primary Care Physician		**Reason for Last Visit**		**Approximately when was your last visit**	
Last Eye Doctor				**Approximately when was your last eye exam**	

What are your visual symptoms? Please MARK any that apply:			
☐ Blurred Vision @ Distance	☐ Burning Eyes	☐ Floaters, Floaters or Spots	☐ Headaches
☐ Blurred Vision @ Near	☐ Itchy Eyes	☐ Halos	☐ Loss of Vision
☐ Double Vision	☐ Red Eyes	☐ Poor Night Vision	☐ Droopy Lid
☐ Eye Strain or Tired Eyes	☐ Watery Eyes	Other:	
☐ Eye Pain/Soreness	☐ Sand/Gritty Feeling		
☐ Eye Infection	☐ Mucous Discharge		

Review Of Systems

Please MARK any current illnesses, symptoms or problems

Constitution: ☐ None ☐ Insomnia ☐ Cancer ☐ Recent Trauma ☐ Development Delay ☐ Other	**Cardiovascular:** ☐ None ☐ High Blood Pressure ☐ Stroke ☐ Heart Disease ☐ High Cholesterol ☐ Coronary Artery Dx (CAD) with/out stent ☐ Other	**Ears, Nose, Throat:** ☐ None ☐ Ringing in Ear ☐ Hearing Loss ☐ Upper Respiratory Tract Infections ☐ Other
Respiratory/Lungs: ☐ None ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD (Chronic obstructive Lung Dx) ☐ Other	**Stomach/Intestines:** ☐ None ☐ Irritable Bowel Syndrome (IBS) ☐ Colitis ☐ GERD/Acid Reflux ☐ Diverticulitis ☐ Other	**Urinary/Reproductive:** ☐ None ☐ Kidney Stones ☐ Other
Bones/Joints/Muscles: ☐ None ☐ Fibromyalgia ☐ Ankylosing Spondylitis ☐ Osteoarthritis Arthritis ☐ Other	**Skin/Hair/Nails:** ☐ None ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Skin Cancer, non melanoma ________ ☐ Melanoma: Location ______________ ☐ Skin Dryness ☐ Other	**Neurological:** ☐ None ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Migraines ☐ Other
Psychiatric: ☐ None ☐ Attention Deficit Hyperactivity (AD/HD) ☐ Attention Deficit Disorder (ADD) ☐ Anxiety ☐ Depression ☐ Dementia ☐ Other	**Endocrine/Hormonal:** ☐ None ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Thyroid (Hyper/Hypo) ☐ Hormonal Dysfunction ☐ Gestational Diabetes ☐ Pre-Diabetes ☐ Other	**Other:**
Blood/Circulation: ☐ None ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Other	**Allergic/Immunologic:** ☐ None ☐ Aids or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Other	

Are You Pregnant?	☐ Yes	☐ No	**Are You Nursing?**	☐ Yes	☐ No
Do you use a computer?	☐ Yes	☐ No	**Hours per day**		
Head or Eye Injuries	☐ Yes	☐ No	**Eye Surgeries**	☐ Yes	☐ No
If yes, please explain:			**If yes, please explain:**		

Last Recorded Diabetic Test (if diabetic)			
Test	**Date**	**Value**	**Location /Timing (Fasting, Post Breakfast, Post Lunch, Post Dinner)**
Blood Sugar			
A1c			

Please document here if your diabetic doctor is different from your PCP listed above:

Name: ______________________________

Clinic: ______________________________

Past / Present Ocular History		
Please MARK any past or present ocular illnesses, symptoms or problems **Please list any additional past or present ocular illnesses, symptoms or problems**		**Date Diagnosed**
Glaucoma	☐ None ☐ Ocular Hypertension ☐ Open Angle ☐ Suspect ☐ Unspecified	
Cataracts	☐ None ☐ Yes ☐ Cataract Surgery ☐ Other	
Macular Degeneration	☐ None ☐ Dry (non-exudative) ☐ Wet (exudative) ☐ Other	
Eye Injury	☐ None ☐ Foreign Body ☐ Burn	
Retinal Disease	☐ None ☐ Floaters ☐ Retinal Detachment ☐ Retinal Tear	
Other Disease	☐ None ☐ Other	
Blindness	☐ None ☐ Congenital ☐ Injury Related ☐ Legally Blind ☐ Other **EYE:** _____	
Strabismus (Crossed Eye)	☐ None ☐ Exotropia (out) ☐ Esotropia (in) ☐ Muscle Surgery ☐ Patching	
Amblyopia (Lazy Eye)	☐ None ☐ One Eye ☐ Both Eyes ☐ Patching ☐ Unknown Type ☐ Other	
Diabetes	☐ None ☐ Diabetic Retinopathy ☐ Other	
Dry Eye	☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Other	
Refractive	☐ None ☐ Glasses Full-time ☐ Glasses Part Time ☐ Glasses Near ☐ Contact Lenses ☐ LASIK ☐ Other	
Other	☐ Vision Therapy ☐ Other	

Family Eye History		
Please list any family members, (grandparents, parents, siblings, children, living or deceased) with these conditions		
Glaucoma	☐ None ☐ Yes	If Yes, relationship:
Cataracts	☐ None ☐ Yes	If Yes, relationship:
Macular Degeneration	☐ None ☐ Yes	If Yes, relationship:
Retinal Disease	☐ None ☐ Yes	If Yes, relationship:
Other Disease	☐ None ☐ Yes	If Yes, relationship:
Blindness	☐ None ☐ Yes	If Yes, relationship:
Strabismus (Crossed Eye)	☐ None ☐ Yes	If Yes, relationship:
Amblyopia (Lazy Eye)	☐ None ☐ Yes	If Yes, relationship:
Other		

Family Health History		
Diabetes	☐ None ☐ Yes	If Yes, relationship:
Cancer	☐ None ☐ Yes	If Yes, relationship:
Heart Disease	☐ None ☐ Yes	If Yes, relationship:
Hypertension	☐ None ☐ Yes	If Yes, relationship:
High Cholesterol	☐ None ☐ Yes	If Yes, relationship:
Kidney Disease	☐ None ☐ Yes	If Yes, relationship:
Unknown	☐ Adopted ☐ Other	
Other		

Social History[2]			
Alcohol Use: ☐ Yes	☐ No	**Illicit Drug Use:** ☐ Yes	☐ No

Tobacco Status:	
☐ Current everyday smoker	☐ Heavy tobacco smoker
☐ Current some day smoker	☐ Light cigarette smoker (1-9 cigarettes/day)
☐ Former smoker	☐ Never smoked

Occupation	
Hobbies	

Medications				
Please list all medications you are taking including prescription, over the counter (OTC), supplements and herbal.				
The government requires the doctors report: Name, Dosage, Frequency, and Route for EACH medication. Please have that available.				
Start Date	**Name** ☐ ***No Medications/Supplements***	**Strength/Dosage**	**Frequency**	**Route or additional information**

Allergies			
Allergy ☐ ***No Known Allergies***	**Onset Date**	**Reaction**	**Severity**

Medical Alerts
Please list all medical alerts (i.e., Do Not Dilate, epilepsy)

Contact Lens History			
Type of contact lenses you currently wear (gas permeable, soft daily, extended)			
Wearing Type (daily, overnight)		**How often do you replace your contacts?** (daily, weekly, monthly)	
Average hours of contact lens wear		**Number of hours worn today**	

Contact lens services are not covered under regular eye exams. In order to obtain a contact lens prescription that maximizes your visual potential and our professional demands, an additional contact lens evaluation must be done. The price of this service varies based on your prescription and complexity of the contacts. Our doctors are committed to your success in contact lenses. If you have any questions regarding the fee, please talk to your doctor.

Glasses History				
Do you wear glasses?	☐ Yes ☐ No	☐ All the time ☐ Sometimes	☐ Work Only ☐ Reading Only	☐ Driving Only
Are you planning to get new glasses today?		☐ Yes	☐ No	

[2]Required due to the one of the following federal laws: American Recovery and Reinvestment Act of 2009, Patient Protection and Affordable Care Act of 2010 (ACA)and/or Health Insurance Portability and Accountability Act of 1996 (HIPAA)