CLARITY EYE CARE, PLLC

2695 East Lincoln Avenue, Suite C • Sunnyside, Washington 98944 • Phone (509) 836-2818 • www.clarityeyecare.net

PATIENT HISTORY

Thank you for choosing our office for your eye care needs. Please complete this form. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Patient name: _____ D.O.B.: ____/____/____ Male or Female

Address:_____ City:_____ St:_____ Zip:_____

Phone #:_____ Alternate #:_____

E-mail address: _____

Employer / Occupation:_____ Insurance:_____

Date of last eye exam:_____ By Whom / Where:_____

Have you worn contact lenses? _____ Do you want color contact lenses? _____

Type of contacts used in past:_____ Type of solutions used in past:_____

Family Doctor's name:_____ Current medications: _____

_____

_____

Check conditions that apply to you / family and write which member has the condition.

____Blurry vision	____Eye diseases	____Allergies
____Double vision	____Macular Degeneration	____Diabetes
____Eye pain	____Glaucoma	____Heart problems
____Eye / Head injury	____Eye surgery	____High blood pressure
____Lazy eye	____Blindness	____Respiratory problems

Please mark a "Y" for Yes or a "N" for No

____Do you work on a computer? ____Do you participate in sports?

____Do you have difficulty driving at night? ____Do you have problems with glare?

How did you hear about our office?

____Previous patient of Clarity Eye Care ____Friend or Family member

____Our Website or the Internet ____Other/Explain_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signed _____Relationship _____ Date: _____/_____/_____