COLUMBIA FALLS EYECARE, PC
Cedarwood West
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Troy R. Ypma, OD

**PATIENT INFORMATION**

**Last: _____First: _____**
**Date of Birth: _____ Age:_____ Sex: M F**
**Mailing address:_____**
**City:_____ State:_____**
**Zip:_____**
**Home Phone:_____**
**Cell:_____**
**Work Phone_____**
**SSN:_____**
**Employer _____**
**Spouse's Name (if applicable):_____**
**Parent and/or guardian's name (if minor):_____**

**PRIMARY MEDICAL INSURANCE**
**Insurance Company:_____**
**Subscriber Name:_____**
**Subscriber DOB:_____**
**Subscriber SSN or Member ID#:_____**

**SECONDARY MEDICAL INSURANCE**
**Insurance Company: _____**
**Subscriber Name:_____**
**Subscriber DOB: _____**
**Subscriber SSN or Member ID#:_____**

**VISION INSURANCE**
**Insurance Company:_____**
**Subscriber Name:_____**
**Subscriber DOB:_____**
**Subscriber SSN or Member ID#:_____**

**Do you currently wear prescription glasses? ☐ Yes ☐ No**
**If Yes, do you wear them: ☐ full-time ☐ part-time**

**Are you planning on purchasing a new frame today? ☐Yes ☐No**

**Do you currently wear contact lenses? ☐ Yes ☐ No**
**If Yes, do you wear them: ☐ full-time ☐ part-time**

**Do you need your contact lens prescription renewed today?**
**☐ Yes ☐ No**

**Are you planning on purchasing contact lenses today? ☐ Yes ☐No**

**PERSONAL MEDICAL HISTORY**

**What is the name/practice of your primary care physician?:**
**_____**
**_____**
**Date of last physical: _____**

**Are you allergic to any medications?: ☐ Yes ☐ No**
**If yes, which one(s):**
**_____**
**_____**

**Have you had any previous eye injuries/surgeries? ☐ Yes ☐ No**
**If yes, please explain:**
**_____**
**_____**

**Have you been diagnosed with:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Glaucoma | | | Cataracts | | |
| Macular Degeneration | | | High Blood Pressure | | |
| Diabetes | | | High Cholesterol | | |

**Have any immediate family members (sibling, parent, grandparent) been diagnosed with:**
**☐ glaucoma ☐ macular degeneration ☐ Type II diabetes?**

**If yes, who?: _____**

**Do you currently: ☐smoke ☐use smokeless tobacco**
**☐ use electronic cigarettes?**

**If not, have you previously? ☐yes ☐no**
**If yes, when did you approximately quit: _____**

**Do you have any medical issues with the following?:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Ears | | | Allergies | | |
| Nose | | | Skin | | |
| Mouth | | | Auto-Immune System | | |
| Throat | | | Neurologic System | | |
| Heart | | | Thyroid | | |
| Lungs | | | Back | | |
| Endocrine System | | | Neck | | |