WELCOME TO OUR OFFICE

Joanne Gronquist, O.D., F.A.A.O.   Tem Gronquist, O.D.

Name (Mr. Mrs. Miss Ms. Dr.)

____

Street ______________________________________

City __________________ State ____ Zip ________

Tel (H) _________________ (W) _______________

(C)_______________________________________

Employer (or School) _________________________

Occupation (or grade) _________________________

Today's Date ____

Birth Date ________________________Age___________________

Social Security # ____

Referred by ____

Person responsible for account ____________________________

Address if different _____________________________________

Emergency contact _______________________________________

Email address ____

Family members who are patients of Dr. Gronquist ____

Date of last eye exam_____________ by Doctor_______________

Have you ever had your eyes dilated? Y N

Would it be convenient to dilate today? Y N

Do you wear glasses? Y N

Age of glasses_____________

Do you wear contact lenses? Y N

Type/Brand______________________

Care system______________________

Reason for today's visit:

____

____

Interested in:

- ☐ Contact Lenses
- ☐ Glasses/Sunglasses
- ☐ LASIK
- ☐ Vision Therapy
- ☐ Low Vision Aids

Do you use Cigarettes/Tobacco, Alcohol, or other susstances?

Yes No

Have you ever been exposed with:

☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphillis

Family History

			Relationship
Blindness	Yes	No	______________
Cataract	Yes	No	______________
Crossed Eyes	Yes	No	______________
Glaucoma	Yes	No	______________
Macular Degeneration	Yes	No	______________
Retinal Conditions	Yes	No	______________
Arthritis	Yes	No	______________
Cancer	Yes	No	______________
Diabetes	Yes	No	______________
Heart Disease	Yes	No	______________
High Blood Pressure	Yes	No	______________
Kidney Disease	Yes	No	______________
Lupus	Yes	No	______________
Thyroid Disease	Yes	No	______________
Other ______________________			______________

Current Medications (Rx and Over the Counter)

	Name of medication
Antihistamines	______________________
Blood Pressure	______________________
Heart Pills	______________________
Insulin	______________________
Oral Contraceptives	______________________
Eye Drops	______________________
Other	______________________

Medical History

Allergies (Please list) Yes No

____

Major Surgeries/Hospitalizations (Please list)

____

Have you ever been diagnosed or treated for the following health problems?

Allergies	Yes	No
Arthritis	Yes	No
Blood/Lymph	Yes	No
Bronchitis	Yes	No
Cancer	Yes	No
Cholesterol	Yes	No
Diabetes	Yes	No
Digestive	Yes	No
Ears/Nose/Throat	Yes	No
Eye Infection	Yes	No
Eye Diseases	Yes	No
Eye Injury	Yes	No
Eye Surgery	Yes	No
Retinal Conditions	Yes	No
Lazy Eye	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Endocrine	Yes	No
Eczema/Rashes	Yes	No
Fatigue	Yes	No
Fevers	Yes	No
Genitourinary	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Integumentary (Skin)	Yes	No
Kidney	Yes	No
Muscle/Bone	Yes	No
Psychological	Yes	No
Respiratory	Yes	No
Sinus Condition	Yes	No
Throat Infections	Yes	No
Thyroid	Yes	No
Unusual weight losses/gains	Yes	No
Headaches/Migraines	Yes	No

Primary Physician ______________________________

For Office Use Only

Dr. Signature ____________________Date________

Life Style Questions	Computer User Questionnaire (Optional)
Do you……(check box if your answer is yes) ❑..Work at a computer? If yes, please complete computer questionnaire. ❑..Think you might benefit from thinner, lighter lenses? ❑..Have interest in a "test drive" of the latest contact lens Designs ❑..Spend time outdoors? How much? __Hrs/week ❑..Have prescription sun wear? ❑..Prefer not to wear your glasses at times? ❑..Want information on Laser Vision Correction surgery? ❑..Have interest in a non-surgical approach to vision correction? ❑..Have more than 1 pair of current Rx eyewear? ❑..Have children? ❑..Have family members in need of eye care?	**Please indicate below if you experience any of these symptoms**: Headaches or fatigue at the computer Yes No Dry, tired, or irritated eyes on the computer Yes No Blurring of distance vision after computer use Yes No Squinting while at the computer Yes No Neck or back pain Yes No Need to interrupt work frequently to rest eyes Yes No If you experience any of these symptoms, we offer a new type of eyewear lens that can eliminate the symptoms and dramatically improve your comfort level when working on a computer. The doctor will explain how these eyewear lenses can help you.

Our Mission

- To preserve the precious gift of sight, with the highest quality vision care in a warm, congenial atmosphere.
- Educate our patients about all that will restore, preserve and enhance their vision.
- To provide the best in comprehensive eye care, service, and quality eyewear.
- To keep up to date with advances in healthcare and medical technology.