Dr. Vida Kazempour & Associates
400 Bellevue Square
Bellevue, WA 98004

We are pleased to welcome you to our practice.
Please fill out this form as completely as you can.
If you have any questions, we will be glad to help you.

Patient information

Name: --	Today's Date: --
Address: --	Date of Birth: --
City/State/Zip Code: --	Occupation: ---
Phone # cell/home: --	Email: --

How did you hear about our office?

REASONS FOR YOUR VISIT (Please check all that apply)

--- Annual eye exam	--- Blurry distance vision	--- Blurry near vision	--- Double vision	--- Distorted vision
--- Office Visit	--- Eye infection	--- Flashes/floaters	--- Lost/broken glasses	--- other ----------------

OCULAR (EYES) HEALTH HISTORY

When was your last eye exam: ----------------- Do you wear glasses: --- YES --- NO

Do you wear Contacts: --- YES --- NO

Are you interested in the contact lens exam today? (**Additional *fee applies***) --- YES --- NO

We are happy to provide you with your prescription for contact lenses upon completion of contact lens fitting service. I have been informed of the possible need to schedule and attend follow up appointments with my optometrist to complete the fitting service. Please Initial ______________

Please check any condition that you may have experienced:

--- Eye injury --- Eye surgery --- Sudden complete loss of vision --- Others: ------------------------------------

Please indicate any personal or family history of the following ocular conditions:		
Blindness	--- Self	--- Family
Cataracts	--- Self	--- Family
Glaucoma	--- Self	--- Family
Macular degeneration	--- Self	--- Family
Retinal disease	--- Self	--- Family

Please indicate any personal or family history of the following medical conditions:		
Seasonal Allergies	--- Self	--- Family
Arthritis	--- Self	--- Family
Cancer	--- Self	--- Family
Diabetes	--- Self	--- Family
Heart Disease	--- Self	--- Family
High Blood Pressure	--- Self	--- Family
HIV/AIDS	--- Self	--- Family
Lupus	--- Self	--- Family
High Cholesterol	--- Self	--- Family
Thyroid Disease	--- Self	--- Family

Are you currently nursing or pregnant? --- YES --- NO

Name of your primary care physician: ---

Address: ---

Dilated fundus exam is part of routine eye exam and highly recommended for patients over the age 40 or anyone with systemic disease like diabetes.

_____ Yes I like to be dilated today

_____ No I don’t like to be dilated

_____ I like to come back on a different day for dilation.

Please list any medication you are currently taking, including eye drops and over the counter:

Please list any medication or substance that you are allergic to:

I understand the information provided is confidential. I give consent to the doctor's office to use this information as needed for my treatment, billing, or obtaining payment for services or for the general business activities specific for the office. This information may be used in other cases as outlined in the full context of the Notice of Privacy Act (HIPAA), which is available for review.

Print name of patient, Parent or Guardian --	Signature of patient, parent or guardian --
Date: --	Relationship to patient: ----------------------------