

# WELCOME TO OUR OFFICE

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

Name (Mr. Mrs. Miss Ms. Dr.) _____	Today's Date _____
Street _____	Birth Date _____ Age _____
City _____ State ____ Zip _____	Social Security # _____
Tel (H) _____ (W) _____	Spouse's (or parents') Name _____
Email address _____	Person responsible for account _____
Employer (or School) _____	Address if different _____
Occupation (or grade) _____	Emergency contact _____
Family members who are patients of Dr. Gronquist _____	Referred by _____

**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

### MEDICAL HISTORY

Allergies (Please list)	Yes	No
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Major Surgeries/Hospitalizations (Please list)

Arthritis	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Sinus condition	Yes	No
Eye Infections	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

Regular exercise            Yes    No

Other \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

### FAMILY HISTORY

	Yes	No	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)

	Yes	No	Name of Medication
Antihistamines	Yes	No	_____
Blood Pressure	Yes	No	_____
Heart Pills	Yes	No	_____
Insulin	Yes	No	_____
Oral Contraceptives	Yes	No	_____
Eye Drops	Yes	No	_____
Other	Yes	No	_____

