WELCOME TO CASTLE ROCK VISION
David R. Clausen, O. D.
Taffy Whiteman, O. D

Today's Date______________________________
Patient Name____ Date of Birth________________
Address____
City___________________________ State_____ Zip_________ Home Phone________________________
Patient's SSN______________________ Parent's Name (if Child) _________________________________
Occupation/Student Status____
Employer____ Work Phone________________________
Do you have vision insurance? Y/N Name of Insurance Carrier_________________________________
Insured Member's Name____
Insured's SSN/ID#________________________ Patient's Relation to Insured______________________
Emergency Contact/Telephone Number____
Date of Last Eye Exam________________________ Dilated? Y/N
What is the reason for today's visit? ____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type________________________________ Date _____________
Have you had an eye injury? Y/N Kind____________________________________ Date _____________
Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N
Macular Degeneration? Y/N Retinal Detachment? Y/N
Other eye problems? Y/N What Kind? ____
Do you wear glasses? Y/N Contact Lenses? Y/N Type____________________________________

PERSONAL MEDICAL INFORMATION

What is your general health? ____
Are you being treated for any illness? ____
Current Medication(s) ____
Diabetes Y/N Type ___________________________________Date of Diagnosis_____________________
Allergies Y/N Allergic to what? ____________________________What happens? ___________________
Medication Allergies Y/N Allergic to what? _________________ What happens? __________________
Headaches Y/N High Blood Pressure Y/N Pregnant or Nursing Y/N
Other health problems ____
Name of family doctor ______________________________Date of last visit__________________________
Date of last tetanus shot _________________________

FAMILY HISTORY

High Blood Pressure Y/N Relation _____________ Macular Degeneration Y/N Relation_____________
Diabetes Y/N Relation ____________________ Retinal Detachment Y/N Relation___________________
Glaucoma Y/N Relation ______________________ Cataracts Y/N Relation ________________________
Other eye condition(s) Y/N What kind? ________________________ Relation ________________________

Additional Information ____
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Whom may we thank for referring you? ____