FRANK HASKELL LIONS EYE CLINIC

800 E. Chestnut St., Suite 3B, Bellingham, WA 98225
Message phone: 360-788-6548

Drop off or mail application to the above address or email to Haskelleyeclinic@bellinghamcentrallions.org.

Today's Date: _____

Name: _____
First/Primer Nombre Middle/Segundo Nombre Last/El Apellido

Address:

_____
Street or P.O. Box City State Zip

County: _____ **Birth Date**: _____/_____/_____ **Age:** _____

Telephone: _____
Home Cell

May we leave a message? ☐ **Yes** ☐ **No** **May we text you?** ☐ **Yes** ☐ **No**

Email: _____

Agency referring you to Haskell Clinic? _____

Are you a veteran? ☐ Yes ☐ No

Have you ever received assistance from the Haskell Eye Clinic? ☐ Yes ☐ No

What assistance are you requesting? ☐ Eye Exam ☐ Glasses ☐ Both

Do you need ADA accommodations? ☐ Yes ☐ No Please explain: _____

Do you have Medicare? ☐ Yes ☐ No Do you have Medicaid? ☐ Yes ☐ No

Do you have any other medical or vision insurance? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Other: _____ Do you need an interpreter? ☐ Yes ☐ No

To Qualify: Financial Income Guidelines Below

Family Size:	Combined Income:	Family Size:	Combined Income:	Family Size:	Combined Income:
1	$30,120	2	$40,880	3	$51,640
4	$62,400	5	$73,160	6	$83,920
	Additional persons + $10,760 ea.				

Total number of people in the household, including yourself: _____

Employment Status: ☐ Full Time ☐ Part-Time ☐ Unemployed Annual Income: _____

--This will be confidential as part of your medical record—

Today's Date: _____

Name: _____ **DOB:** _____
First Middle Last

VISUAL HISTORY

What is the main reason for today's exam? _____
What was the date of your last exam? _____
Current Occupation: _____ Do you use a computer? Yes No
Do you drive: Yes No Do you have difficulty when driving? Yes No
Do you have problems with night vision? Yes No

SPECTACLE LENS HISTORY

Do you currently wear glasses? Yes No Since: _____
Type of glasses: Full Time Part Time Distance Close
Do you currently wear contact lenses? Yes No Since: _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? Yes No
Do you engage in regular exercise? Yes No Do you drink alcohol? Yes No
Do you smoke? Yes No Do you use recreational drugs? Yes No
Hobbies/Interests: _____

EYE HISTORY

Headaches	Yes	No	Mucous Discharge	Yes	No
Glare/Light Sensitivity	Yes	No	Redness	Yes	No
Lazy Eye	Yes	No	Crossed Eyes	Yes	No
Burning/Dryness	Yes	No	Blurred Vision	Yes	No
Eye Pain or Soreness	Yes	No	Double Vision	Yes	No
Infection of Eye or Lid	Yes	No	Floaters or Spots	Yes	No

GENERAL HEALTH CONDITION

Kidney	Yes	No	Blood/Lymph	Yes	No
Muscles, Bones	Yes	No	Allergic/Immunologic	Yes	No
Skin	Yes	No	Ears, Nose, Throat	Yes	No
Neurological (MS)	Yes	No	Cardiovascular	Yes	No
Diabetes, Thyroid	Yes	No	High Blood Pressure	Yes	No
HIV/AIDS	Yes	No	Breathing Problems	Yes	No
Fever	Yes	No	Gastrointestinal	Yes	No
High Cholesterol	Yes	No	Other Symptoms	Yes	No

Past Illnesses, Injuries or Surgeries: _____
Current Medications: _____
_____
Have you been prescribed medications that you do not use? _____
Medicines that cause reactions or sensitivities? _____
Specific Allergies: _____

FAMILY HISTORY

Lazy Eye	Yes	No	Arthritis	Yes	No	Diabetes	Yes	No
Cataract(s)	Yes	No	Color Blindness	Yes	No	Kidney Disease	Yes	No
Blindness	Yes	No	Cancer	Yes	No	Lupus	Yes	No
Glaucoma	Yes	No	Heart Disease	Yes	No	Stroke	Yes	No
Macular Degeneration	Yes	No	Thyroid Disease	Yes	No	Retinal Detachment	Yes	No
Eye Turn	Yes	No	High Blood Pressure	Yes	No	Other	Yes	No