



FRANK HASKELL LIONS EYE CLINIC

800 E Chestnut St., Bellingham, WA 98225
bellinghamcentrallions.org

Return application to the above address and we will contact you regarding an appointment time or the next step.

Today's Date: _____

Name:

First

Middle

Last

Address:

Street or P.O. Box

City

State

Zip

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

Month / Day / Year

Telephone: _____

Home #

Message or Cell #

May we leave a message? Yes No If so, which number? _____

Email: _____

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

What assistance are you requesting: Eye Exam Glasses

Do you need ADA accommodations? Yes No Please Explain: _____

Do you have Medicare: Yes No Medicaid: Yes No Other: _____

Do you have any other vision insurance? Yes No

If you have Medicare/Medicaid or other public health coverage, you must obtain an exam from a clinic accepting this coverage. A list is available on request.

What is your housing status?

Own Rent Staying with family/friends Homeless Other _____

Employment Status:

Full Time Self-employed
 Part Time Retired
 Temporary Unemployed

Sex:

M
 F

Marital Status:

Single
 Married
 Divorced

OFFICE USE ONLY: do not write in this space

FRANK HASKELL LIONS EYE CLINIC – QUALIFYING FINANCIAL INFORMATION

-This will be kept confidential-

Name: _____ Date: _____

TO QUALIFY:

1. **PRIORITY WILL BE GIVEN TO WHATCOM COUNTY RESIDENTS**
2. **MUST MEET FINANCIAL INCOME GUIDELINES BELOW**

Family Size:	Combined Income:	Family Size:	Combined Income:	Family Size:	Combined Income:
1	\$21,780	2	\$29,420	3	\$37,060
4	\$44,700	5	\$52,340	6	\$59,980
Additional persons + \$7,640 ea.					

Do you have dependent children living with you? Yes No If so, how many? _____

Total number of people in household, including yourself: _____

Household Monthly Income:

Employer(s): _____

Salary: \$ _____

Dividend/Interest: \$ _____

Social Security: \$ _____

Other: \$ _____

TOTAL INCOME: \$ _____

Household Monthly Expenses:

Rent/Mortgage: \$ _____

Utilities: \$ _____

Insurance: \$ _____

Phone: \$ _____

Other: \$ _____

TOTAL Expenses: \$ _____

You have brought the following required documents:

- 1) Proof of Income: present one
 - tax return; or
 - pay stubs (from all sources of income: work, SSI, etc.); or
 - DSHS/Food Stamp completed application
- 2) Proof of Residence: present one
 - rental agreement; or
 - power/utility bill; or
 - Lighthouse Mission Ministries Resident

For further information please contact WAHA – Whatcom Alliance for Health Advancement
(360) 788-6594 ▪ whatcomalliance.org

FRANK HASKELL LIONS EYE CLINIC – PATIENT HISTORY AND INFORMATION

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

Name: _____ Date: _____

VISUAL HISTORY

What is the main reason for today's exam? _____

When was your last exam? _____

Current Occupation: _____ Years: _____ Employer: _____

Do you use a computer? Yes No Hours/day _____

Do you drive? Yes No Do you have glare problems? 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

Glasses Owned: Single Vision Bifocals Trifocals Back-up Glasses Safety Glasses
 Sports Glasses Progressive

Have you had trouble in the past with glasses? Yes No Explain: _____

CONTACT LENS HISTORY

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

If yes, how much/often: Occasional 1 per day 2-3/day 4+/day

Do you smoke? Yes No

If yes, how much/often: Occasional 1/2 pack/day 1 pack/day 1+pack/day

Do you use 'recreational' drugs? Yes No

Hobbies/Interests: _____

FRANK HASKELL LIONS EYE CLINIC – PATIENT HISTORY AND INFORMATION

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EYE HISTORY

- | | | | |
|-------------------------|--|--------------------------|--|
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drooping Eyelid | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glare/Light Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No | Redness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tired Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sandy/Gritty Feeling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lazy Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | Crossed Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blurred Vision Distance | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dryness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blurred Vision Near | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excess Tearing/Watering | <input type="checkbox"/> Yes <input type="checkbox"/> No | Distorted Vision (halos) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Pain or Soreness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Double Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foreign Body Sensation | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters or Spots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infection of Eye or Lid | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fluctuating Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Itching | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mucous Discharge | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Side Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |

GENERAL HEALTH CONDITION

- | | | | |
|------------------------|--|--|--|
| Kidney | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood/Lymph (cholesterol) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Muscles, Bones, Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergic/Immunologic | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Skin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ears, Nose, Throat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neurological (MS) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiovascular/
High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes, Thyroid | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breathing Problems (asthma) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastrointestinal | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Other Symptoms | <input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataract(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Macular Degeneration | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Retinal Detachment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Turn | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Others | <input type="checkbox"/> Yes <input type="checkbox"/> No |