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

revised 06/04/19

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

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: _____

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

EYE HISTORY

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

GENERAL HEALTH CONDITION

Kidney	☐ Yes ☐ No	Blood/Lymph (cholesterol)	☐ Yes ☐ No
Muscles, Bones, Joints	☐ Yes ☐ No	Allergic/Immunologic	☐ Yes ☐ No
Skin	☐ Yes ☐ No	Ears, Nose, Throat	☐ Yes ☐ No
Neurological (MS)	☐ Yes ☐ No	Cardiovascular/	
Diabetes, Thyroid	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Breathing Problems (asthma)	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Gastrointestinal	☐ 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
Blindness	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Cataract(s)	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Eye Turn	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Others	☐ Yes ☐ No