Vision Source Owasso

Patient Name: _____ **DOB:**_____
Address:_____ **Social Security Number Last 4:**_____
_____ **Male/Female**_____
Phone Number:_____ **Email Address:** _____
Emergency Contact Name and Phone Number: _____
Primary Care Doctor:_____

Do you wear glasses Y/N **Contacts** Y/N
Reason for Today's Visit? _____

Medical History:

Please list Medications or OTC supplements that you are currently taking?

_____
_____
_____

(Please circle all that apply)

ENT
Hearing Loss
Sinusitis

Neurological
Multiple Sclerosis
Epilepsy
Migraines

Psychiatric
ADD/ADHD
Anxiety Disorder
Bipolar Disorder

Cardiovascular
High Blood pressure
Stroke/CVA/Heart Attack
Heart Disease
Congestive Heart Failure

Constitutional
Cancer

Respiratory
Asthma
Bronchitis
COPD
Sleep Apnea

Gastrointestinal
Crohn's
Acid Reflux

Genitourinary
Kidney Disease
Prostate Cancer
BPH

Pregnant/Nursing
Musculoskeletal
Osteoarthritis
Arthritis
Fibromyalgia
Osteoporosis

Skin(Integumentary)
Eczema
Psoriasis
Herpes Simplex/Cold sores
Shingles

Endocrine
Diabetes Type 1 or 2
Hyperthyroid
Hypothyroid

Hematologic/Lymphatic
Anemia
High Cholesterol
Allergies/Autoimmune
Rheumatoid Arthritis
Lupus
Sjogren's

Hepatitis A B C

HIV/AIDS

Other Conditions not listed above?

_____

Allergies to medications?
Y/N _____
Other allergies?

_____

More on Back

Ocular History:

Have you been diagnosed with any of the following?

Glaucoma	Y/N	Cataracts	Y/N	LASIK, PRK or RK Surgery	Y/N
Macular Degeneration	Y/N	Amblyopia (lazy eye)	Y/N	History of Eye Trauma	Y/N
Retinal Disease	Y/N	Strabismus (eye turn)	Y/N	Other Eye Surgery	Y/N

Social History:

Are you pregnant/nursing? Y/N

Do you use cigarettes? Y/N Tobacco Y/N Alcohol Y/N Previous smoker Y/N

Occupation: _____ Hobbies: _____

Family History:

Have you or your family member been treated for any of the following? (circle all that apply)

Cancer	Y/N	Dad	Mom	Sister	Brother	Son	Daughter
Diabetes	Y/N	Dad	Mom	Sister	Brother	Son	Daughter
High Blood Pressure	Y/N	Dad	Mom	Sister	Brother	Son	Daughter
Thyroid	Y/N	Dad	Mom	Sister	Brother	Son	Daughter
Macular Degeneration	Y/N	Dad	Mom	Sister	Brother	Son	Daughter
Glaucoma	Y/N	Dad	Mom	Sister	Brother	Son	Daughter
Cataract	Y/N	Dad	Mom	Sister	Brother	Son	Daughter