Clinton Vision Source • 565 S 30th St • Clinton, OK 73601 • 580-323-5421

Patient Information Date _____/_____/_____

Mr. Ms.

Name Mrs. Dr._____ Preferred Name_____

Address_____ City, State, Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Sex M F DOB ____/____/____ SSN_____ Race/Ethnicity_____ Can we text you? Y N

Occupation_____ Employer _____ E-Mail_____

Marital Status S M D W Spouse Name_____ Spouse Phone_____

Responsible Party Information

Name_____ Relationship_____ Phone_____

Address (if different)_____ City, State, ZIP_____

DOB____/____/____ SSN_____ Employer_____ Employer Phone_____

Insurance _____ Member Name_____ Member ID_____

Insured's Relationship to patient: Self / Spouse / Parent / Guardian

Medical Information (circle all that apply)

Allergies (please list)

_____

_____

_____

_____

Cardiovascular
- High blood pressure
- High cholesterol
- Heart disease
- Stroke
- Other_____

Constitutional
- Dizziness/fainting
- Unexplained weight change
- Appetite change
- Other_____

Endocrine
- Diabetes (Type 1, 2, or borderline)
- Thyroid
- Kidney disease
- Hypoglycemia
- Gout
- Other_____

Gastrointestinal
- Acid reflux
- Liver disease
- Stomach ulcers
- Irritable bowl syndrome
- Diverticulosis
- Other_____

Genitourinary
- Bladder disorder
- Prostate disease
- Menopause
- Ovarian/Uterine disease
- Other_____

Head
- Dry mouth
- Headaches/migraines
- Hearing loss
- Sinus disorder
- Other_____

Hematologic/Lymphatic
- Blood disorder
- Anemia
- Lymph node disease
- Other_____

Immunologic
- AIDS/HIV
- Herpes simplex
- Shingles
- Lupus
- Other_____

Integumentary
- Acne rosacea
- Dry skin
- Skin Cancer
- Albinism
- Other_____

Musculoskeletal
- Osteoarthritis
- Rheumatoid arthritis
- Myasthenia gravis
- Spine disorder
- Other_____

Neurological
- Bell's Palsy
- Brain cancer/disease
- Down Syndrome
- Multiple Sclerosis
- Seizure disorder
- Parkinson's
- Other_____

Psychiatric
- Depression/Mood disorder
- ADD/ADHD
- Alzheimer's/Dementia
- Autism
- Bipolar
- Learning disability
- Other_____

Respiratory
- Asthma
- Lung cancer
- Tuberculosis
- COPD
- Emphysema
- Other_____

Name of Family Doctor _____Date of last visit_____

Please fill out both sides of this sheet

List any operations you have had and approximately when _____

_____

_____

Please list all medications (even over-the-counter) and what you take them for:

_____ for _____ _____ for _____

_____ for _____ _____ for _____

_____ for _____ _____ for _____

_____ for _____ _____ for _____

_____ for _____ _____ for _____

_____ for _____ _____ for _____

_____ for _____ _____ for _____

Alcohol Use (circle one): None Social Use 1-2 drinks daily Above average use Alcohol dependent

Tobacco Use (circle one): None Current Smoker: (packs per day_____, years smoked_____)

Past Smoker Current Smokeless Tobacco User Past Smokeless User

Narcotics Use (circle one): None Recreational Chemical Dependence

Sexually Transmitted Disease (circle one): None Yes HIV Positive

Personal Eye History

Have you ever had cataract surgery? Y / N When? Right Eye_____ Left Eye_____

Laser after cataract surgery? Y / N When? Right Eye_____ Left Eye_____

Any other eye operations? Y / N _____

Any eye injuries? Y / N _____

Have you ever been told you have: Glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N

Macular Degeneration? Y / N Eye Turn? Y / N Lazy Eye? Y / N

Other Eye Disease? Y / N _____

Do you wear: Glasses? Y / N Date of last glasses_____ Contacts? Y / N Brand_____

Date of last eye exam_____Dr._____

Family History (parents, siblings, children, grandparents)

Glaucoma? Y / N Relation_____ Macular Degeneration? Y / N Relation_____

Cataracts? Y / N Relation_____ Retinal Detachment? Y / N Relation_____

Other Eye Conditions? Y / N

Describe_____

Please list pertinent medical diseases in your family and relation:

_____

_____

_____