DeSoto EYE & EAR

Patient Information - Vision

Date _____

Name _____
First Middle Last

Address _____
City State Zip

Home Telephone _____ Work _____ Cell _____

Social Security Number _____ Date of Birth _____

Vision Insurance _____

Occupation _____ Employer _____

Emergency Contact _____ Emergency Telephone _____

Person responsible for payment _____

Previous Optometrist/Ophthalmologist _____

Date of last eye exam _____ Dilated _____ Todays Date _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems?

Eyes	☐ Yes ☐ No	Gastroeintestinal	☐ Yes ☐ No	Nervous	☐ Yes ☐ No
Mental	☐ Yes ☐ No	Ear/Nose/Throat	☐ Yes ☐ No	Genitourinary	☐ Yes ☐ No
Endocrine (glands)	☐ Yes ☐ No	Cardiovascular	☐ Yes ☐ No	Musculoskeletal	☐ Yes ☐ No
Blood/lymph	☐ Yes ☐ No	Respiratory	☐ Yes ☐ No	Integumentary (skin)	☐ Yes ☐ No
Allergic/immunologic	☐ Yes ☐ No				

Please answer all that apply

Diabetes ☐ Yes ☐ No Type, Date of diagnosis _____

Allergies ☐ Yes ☐ No Allergic to what? What happens? _____

Medication allergy ☐ Yes ☐ No To what? What happens? _____

Headaches ☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No

OTHER HEALTH PROBLEMS

Current medications _____

Have you had any operations? ☐ Yes ☐ No Kind? _____

Do you use cigarettes/tobacco? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No Other Substances? ☐ Yes ☐ No

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure ☐ Yes ☐ No Relation _____

Macular Degeneration ☐ Yes ☐ No Relation _____

Diabetes ☐ Yes ☐ No Relation _____

Retinal detachment ☐ Yes ☐ No Relation _____

Glaucoma ☐ Yes ☐ No Relation _____

Cataracts ☐ Yes ☐ No Relation _____

Other eye conditions ☐ Yes ☐ No Relation _____

PERSONAL EYE INFORMATION

Have you had any eye operations? ☐ Yes ☐ No Type _____ Date _____

Have you had an eye injury? ☐ Yes ☐ No Type _____ Date _____

Do you have Glaucoma? ☐ Yes ☐ No

Cataracts? ☐ Yes ☐ No

Dry eyes? ☐ Yes ☐ No

Blurred vision? ☐ Yes ☐ No

Other eye problems? ☐ Yes ☐ No What kind? _____

Do you wear glasses? ☐ Yes ☐ No

Contact lenses? ☐ Yes ☐ No Type _____

Additional information _____

Whom may we thank for referring you? _____