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 _____ Today's Date _____

## MEDICAL INFORMATION

What is your general health? _____

**Do you have problems with any of these systems?**

| | | | | | |
|---|---|---|---|---|---|
| Eyes | ☐ Yes ☐ No | Gastrointestinal | ☐ 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 _____

5740 Getwell Road, Building 3, Unit B, Southaven, MS 38672
(662) 510-2138 www.desotoeyeandear.com

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? _____

Patient Signature _____