SHEPARD AND QUINTON VISION CARE

Full Name _____ Birth Date _____ SS # _____
Preferred Name _____ Marital Status: Married Single Other Gender: M / F
Address _____ City _____ State ____ Zip _____
Home Phone _____ Email _____ Weight _____Height _____
Cell Phone _____ Spouse's Name _____
Race: White American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander
Ethnicity: Hispanic/Latino Not Hispanic/Latino
Preferred Language: English / Arabic / French / German / Italian / Polish / Russian / Spanish / American Sign / Other
Status: Student Employed Other **Employer or School** _____
If patient is a **CHILD:** Responsible Party Name _____ Birth Date _____ SS#_____
Do you wear Glasses ____ Contacts ___ **Primary Care Physician's Name** _____

Self - Past Ocular History
__Cataract
__Glaucoma
__Macular Degeneration
__Eye Surgery
Other _____

Self – Past Medical History
__Hypertension
__Diabetes
__High Cholesterol
Other _____

Social History
Occupational Visual Needs _____
Hobbies _____
Sports/ Recreation _____
Alcohol Use: Never Socially Daily

Family – Past Ocular History:

	Which Member		Which Member
Glaucoma	_____	Cancer	_____
Cataract	_____	Eye Surgery	_____
Macular Degeneration	_____	Hypertension	_____
Diabetes	_____	Cholesterol	_____

PATIENT Review Of Systems: (Circle all that apply.)

Allergic/ Immunologic
Drug Allergy
Environmental Allergy
Rheumatoid Arthritis
Lupus
Other _____

Eyes
Glaucoma
Cataract
Macular Degeneration
Surgery
Inflammatory Disorder
Blurred Vision
Double Vision
Other _____

Musculoskeletal
Fibromyalgia
Muscular Dystrophy
Osteoarthritis
Ankylosing Spondylitis
Other _____

Cardiovascular
Heart Disease
Hypertension
Stroke
Vascular Disease
Other _____

Gastrointestinal
Crohn's Disease
Colitis
Ulcer
Digestive
Other _____

Neurological
Multiple Sclerosis
Epilepsy
Alzheimers
Parkinsons
Cerebrovascular
Other _____

Constitutional
Developmental Disability
Weight Loss
Fever
Fatigue
Trauma
Other _____

Genitourinary
STD, Viral Herpetic, chlamydia
Other _____

Psychiatric
Depression
Panic Disorder
Schizophrenia
Other _____

Ear, Nose, Mouth, Throat
Upper Resp. Tract Infection
Ear Ache
Ringing/Tinitis
Other _____

Hematologic/Lymphatic
Anemia
Large Volume Blood Loss
Leukemia
Other _____

Respiratory
Smoke: Never, Former, Daily
Asthma
Bronchitis
Emphysema
Other _____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____

Endocrine
Non-Insulin Dep. Diabetes
Insulin Dependent Diabetes
Thyroid Dysfunction
Hormonal Dysfunction
Other _____

Integumentary
Eczema
Rosacea
Psoriasis
Other _____

Patient Drug Allergies:_____
_____
I have No Drug Allergies ___