Vision Source™

DOUGLAS D. CREGER, OPTOMETRIST, JOHN E. CREGER, OPTOMETRIST

Date:________________ ________
Patient:________________________

Patient Date of Birth:________________________
Name of family physician:________________________

GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches
☐ Numbness
☐ Other: Meds:

EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ ChronicColds
☐ Other:
Meds:

CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue
☐ Developmental Disability ☐ Trauma ☐ Other:
Meds:

CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease
☐ Stroke ☐ High Cholesterol ☐ Chest Pain
☐ Irregular Heart Beat
☐ Other: Meds:

MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain
☐ Muscle Aches ☐ Other:
Meds:

RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing
☐ Coughing ☐ Other:
Meds:

INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne
☐ Cancer ☐ Excessive Dryness ☐ Other:
Meds:

ALLERGIC/IMMUNE ☐ No Problem
☐ Rheumatoid Arthritis ☐ Lupus ☐ HIV
ALLERGIES:________________________
DRUG ALLERGIES:________________________
Meds:

ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other
Meds:

BLOOD ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

PSYCHIATRIC (Mental) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Infection
☐ Blood in Urine ☐ Other:
Meds:

EYE CONDITIONS: Have you had or do you have any of the following:

Cataracts ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No
Dry Eyes ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No
Floaters/Spots ☐ Yes ☐ No
Flashes of light ☐ Yes ☐ No
Burning ☐ Yes ☐ No
Tearing/Watering Eyes ☐ Yes ☐ No
Itchiness ☐ Yes ☐ No

Describe any special visual needs:

SOCIAL: Please answer:
Do you use Alcohol? ☐ Yes ☐ No Amount: ________________
Do you use Tobacco? ☐ Yes ☐ No Amount:: ________________
Do you use any other substances? ☐ Yes ☐ No What:________________

FAMILY HISTORY Do any family members have any of the following problems (please list paternal or maternal if applicable):

High blood pressure ☐ Yes ☐ No Relation________________
Diabetes ☐ Yes ☐ No Relation________________
Glaucoma ☐ Yes ☐ No Relation________________
Macular Degeneration ☐ Yes ☐ No Relation________________
Retinal Detachment ☐ Yes ☐ No Relation________________
Cataracts ☐ Yes ☐ No Relation________________

Other Eye Conditions ☐ Yes ☐ No Relation________________
Description________________________

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