VISION SOURCE™

DR. DOUGLAS CREGER, OPTOMETRIST

Date: _____ _____
Patient: _____

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

Please describe any problems with the following health systems:

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

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

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

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

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

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

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

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

INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne
☐ Cancer ☐ Excessive Dryness ☐ Other:
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	Macular Degeneration	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Floaters/Spots	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Flashes of light	☐ Yes	☐ No
Dry Eyes	☐ 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 _____	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 _____
Description _____