Frankfort Vision Center

Dr. Karoline L. Munson, Optometrist

Patient Name:_____ Date of Birth:_____

Primary Care Physician/Location:_____

Pharmacy/Location:_____

REVIEW OF SYSTEMS – Do you currently have any of the following conditions?

System	Yes/No	Date Diagnosed	Condition/Current Therapy/Surger
Constitutional(fever, recent weight loss/gain, other,	□Yes □No		
Nose/Mouth/Throat/ Ears(reduced hearing, hearing loss, tubes, other)	□Yes □No		
Neurological(headache, migraine, seizures, dementia, Alzheimer's, Autism Spectrum Disorder, paralysis, other)	□Yes □No		
Psychiatric(depression, anxiety, OCD, ADD, ADHD, schizophrenia, bipolar, other)	□Yes □No		
Vascular(high blood pressure, heart attack, heart disease, high cholesterol, stroke, other)	□Yes □No		
Respiratory(asthma, COPD, sleep apnea, TB, other)	□Yes □No		
Gastrointestinal (acid reflux/heartburn, ulcers, Celiac Disease, other)	□Yes □No		
Genitourinary(kidney, prostate, nursing, STD, herpes, other)	□Yes □No		
Musculoskeletal(osteoporosis, arthritis, RA, Fibromyalgia, osteoarthritis, other)	□Yes □No		
Dermatological(psoriasis, eczema, rosacea, rashes, Shingles, other)	□Yes □No		
Endocrine(Diabetes, gestational diabetes, thyroid, other) **Diabetics:** Average Blood Sugar _____ last A1C_____	□Yes □No		
Hematological(anemia, bleeding disorder, lymph edema)	□Yes □No		
Allergic/Immunologic(allergies, hay fever, HIV, Lupus)	□Yes □No		
Cancer(Type:_____)	□Yes □No		
FEMALES: Are you pregnant?	□Yes □No	Due Date:	

History of Eye Surgeries

Procedure	Reason	When?

MEDICINE HISTORY: Please list all of the medicine, including over the counter, that you currently take:

Are you allergic to any medicine? □Yes □No **Please list:**

Please TURN OVER and complete the other side. Thank you!☺

FAMILY OCULARHISTORY: Does anyone in your immediate family have the following? (PARENTS, SIBLINGS, AND CHILDREN ONLY)		
Glaucoma	□Yes □No Who:	
Cataracts	□Yes □No Who:	
Macular Degeneration	□Yes □No Who:	
Retinal Disease/Detachment	□Yes □No Who:	
Other Eye Diseases	□Yes □No Who:	List:
Blindness	□Yes □No Who:	

FAMILY MEDICAL HISTORY: Does anyone in your immediate family have the following?	
Diabetes	□Yes □No Who/Type:
Cancer	□Yes □No Who/Type:
Hypertension (High Blood Pressure)	□Yes □No Who:
Hyperthyroidism (Overactive)	□Yes □No Who:
Hypothyroidism (Underactive)	□Yes □No Who:

SOCIAL HISTORY: Please answer these questions about yourself:

Marital Status (check one): □Married □Divorced □Single □Widowed

List children names and ages in your home:

Currently Employed: □Yes □No Occupation:_____

What are your hobbies?

Tobacco Use: Do you smoke? □Yes □No # Packs per day?_____ Do you chew? □Yes□No # tins per day?_____

Alcohol Use: How much alcohol do you consume?Please check one:
□None □Social □Weekends(_____drinks per weekend) □Daily(____drinks a day)

Illegal drug use: Do you use illegal drugs? □Yes □No

Visual Function Questions: Please check Yes or No if you are experiencing any of the following:

Visual Problem	Yes/No	Comments
Glare/Reflections when driving	□Yes □No	
Eyes that feel dry, sandy or gritty	□Yes □No	
Eyes that burn, itch or water	□Yes □No	
Crusting or redness on your eyelids	□Yes □No	

Please list all individuals you authorize to receive information about your care:

Individual	Relationship	Phone Number

Patient's Signature:_____ Date:_____