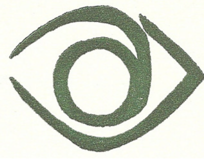

Frankfort Vision Center

Dr. Karoline L. Munson, Optometrist

Patient Name:____ **Date of Birth:**________________________

Primary Care Physician/Location/Phone:____

Pharmacy/Location/Phone:____

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

System	Yes/No	Date Diagnosed	Condition/Current Therapy/Surgery
Eye disease, eye injury, eye surgery	□Yes □No		
Constitutional(fever, recent weight loss/gain, other)	□Yes □No		
Ears (reduced hearing, hearing loss, tubes, other)	□Yes □No		
Nose/Mouth/Throat (chronic sinusitis or other)	□Yes □No		
Vascular (high blood pressure, heart attack, heart disease, high cholesterol, stroke, other)	□Yes □No		
Respiratory (asthma, COPD, emphysema, sleep apnea, TB, home oxygen use, other)	□Yes □No		
Gastrointestinal (acid reflux/heartburn, gallstones, hepatitis, GERD, IBS, stomach ulcers, other)	□Yes □No		
Neurological(headache, migraine, ADHD, ADD, seizures, dementia, Alzheimer's, numbness, paralysis, other)	□Yes □No		
Genitourinary (kidney or urinary problems, other)	□Yes □No		
Dermatological (psoriasis, eczema, rosacea, rashes, other)	□Yes □No		
Musculoskeletal (osteoporosis, arthritis, RA, other)	□Yes □No		
Allergic/Immunologic(allergies, hay fever, HIV, other)	□Yes □No		
Psychiatric (depression, anxiety, OCD, schizophrenia, etc)	□Yes □No		
Hematological(anemia, bleeding disorder, lymph edema)	□Yes □No		
Endocrine(Diabetes, gestational diabetes, thyroid, other) **Diabetics:** Average Blood Sugar ________ last A1C______	□Yes □No		
Cancer (Type:_____________________________________)	□Yes □No		
FEMALES: Are you pregnant?	□Yes □No	Due Date:	

History of any Major Illnesses, Injuries or 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 HISTORY: Does anyone in your family have the following?	
Diabetes	□Yes □No
Glaucoma	□Yes □No
Cataracts	□Yes □No
Macular Degeneration	□Yes □No
Retinal Disease/Detachment	□Yes □No
Other Eye Diseases	□Yes □No **List:**____________________
Blindness	□Yes □No

SOCIAL HISTORY: Please answer the following 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:___________________

☺☺☺☺☺☺☺ Thank You for filling out this form! The rest is for the doctor.☺☺☺☺☺☺☺☺☺

Optometrist's Signature:______________________________________ Date___________________

Review/Update Date	Interval Change	Comments/Signature
	□Yes □No	
	□Yes □No	
	□Yes □No	
	□Yes □No	