VISION SOURCE™

Meigs Clinic
Robyn A Pape, OD

Welcome to our office!
Thank you for choosing us to be your eye care provider.
Please provide us with the following information so that we may serve you better!

Patient Name: _____ Sex: M F

Date of Birth: _____ SSN:_____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Ok to text: Yes / No

Email Address: _____

Marital Status: __Single__Married__Widowed Employment Status: Full time / Part time

Employer: _____ Occupation: _____

Race: _____ Preferred Language: _____

Ethnicity (circle one:) Hispanic/Non-Hispanic

When was your last eye exam?	_____	Are you pregnant or nursing?	Yes / No
Where at?	_____	Tobacco or vape?	Yes / No
Primary Care Physician?	_____	Use smokeless tobacco?	Yes / No
Height and Weight	_____	Drink alcohol?	Yes / No
History of Eye Surgery	Yes / No	Use other substances?	Yes / No

Do you have any of the following problems? Circle any that apply:

Blurry at near / Blurry at distance	Eye pain	Sensitive to light	Double vision
Poor night vision and/or glare	Flashes or Floaters	Eyes burn / itch / water	Redness

Do **YOU** or **ANY OF YOUR BLOOD RELATIVES** have any of the following conditions?
Please write Self, Father, Mother, Brother, Sister, Son, Daughter)

Cancer		_____	Macular Degeneration	_____
Diabetes	Type 1 or 2	_____	Cataract	_____
Thyroid Disease	High or Low	_____	Glaucoma	_____
High Blood Pressure		_____	Amblyopia (Lazy Eye)	_____

See Other Side

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Patient Health History

Please circle any condition that you currently have:

ENT
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis

Neurological
Multiple Sclerosis
Epilepsy
Cerebral Palsy
Tumor
Stroke/CVA
Migraine
Autism

Psychological
Depression
Attention Deficit
Anxiety Disorder
Bipolar Disorder

Cardiovascular
Hypertension
Stroke/CVA
Heart Disease
Vascular Disease
Congestive Heart Failure

Respiratory
Asthma
Bronchitis
Emphysema/COPD
Sleep Apnea

Gastrointestinal
Crohn's
Colitis
Ulcer
Acid Reflex
Celiac Desease

Genitourinary
Kidney Disease
Prostate Disease
STD

Musculoskeletal
Arthritis / Osteoarthritis
Fibromyalgia
Muscular Dystrophy
Osteoporosis
Gout

Dermatological
Eczema
Rosacea
Psoriasis
Herpes Simplex/Cold Sores
Herpes Zoster/Shingles

Endocrine
Type 1 Diabetes
Type 2 Diabetes
Thyroid Dysfunction
Hormonal Dysfunction

Hematologic/Lymphatic
Anemia
Large-Volume Blood Loss
Ulcer
High Cholesterol

Allergy/Immune
Environmental Allergies
Rheumatoid Arthritis
Lupus
Sjogren's Syndrome

Other: _____

_____

Current prescription/non-prescription medications (including eye drops)

_____

_____

_____

Medication Allergies: _____

_____