VISION SOURCE®
OPTOMETRIC VISION CENTER

Date: _____

Family History:

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

CONDITION	NO	YES	relation		NO	YES	relation		NO	YES	relation
Blindness	☐	☐	_____	Macular Degeneration	☐	☐	_____	Heart Disease	☐	☐	_____
Cataract	☐	☐	_____	Retinal Detachment	☐	☐	_____	Arthritis	☐	☐	_____
Crossed Eyes	☐	☐	_____	Diabetes	☐	☐	_____	Cancer	☐	☐	_____
Glaucoma	☐	☐	_____	High Blood Pressure	☐	☐	_____	Thyroid Disease	☐	☐	_____

Review of Systems: (Patient)

Do you currently, or have you ever had any problems in the following areas:

EYES	NO	YES
Glaucoma	☐	☐
Cataract	☐	☐
Eye Surgery/Laser	☐	☐
Eye Injury	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Eye Pain/Ache	☐	☐
Discharge	☐	☐
Crossed/Lazy Eye	☐	☐
Blind Eye	☐	☐
Loss of Vision	☐	☐
Double Vision	☐	☐
Blurry Vision	☐	☐
Spots/Floaters	☐	☐
Halos	☐	☐
Sandy/Gritty Feeling	☐	☐
Dryness	☐	☐
Itching/Burning	☐	☐
Excess Redness	☐	☐
Excess Tearing	☐	☐
Excess Light Sensitivity	☐	☐
Light Flashes	☐	☐

CARDIO/VASCULAR	NO	YES
High Blood Pressure	☐	☐
Heart/Vascular Disease	☐	☐
Stroke	☐	☐
CONSTITUTIONAL		
Fever	☐	☐
Weight Loss/Gain	☐	☐
Cancer	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid Problem/Surgery	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
Acid Reflux	☐	☐
Colitis/Irritable Bowel Syn	☐	☐
Ulcer	☐	☐
GENITOURINARY		
Kidney/Bladder Problems	☐	☐
Prostate	☐	☐
Gall Bladder	☐	☐
EARS, NOSE AND THROAT		
Allergies/Hayfever	☐	☐
Chronic Cough	☐	☐
BLOOD/LYMPHATIC		
Anemia	☐	☐
Bleeding/Clotting Prob	☐	☐

INTEGUMENTARY	NO	YES
Skin Problems/Disorders	☐	☐
Acne/Rosacea	☐	☐
Psoriasis/Eczema	☐	☐
BONES/MUSCLES		
Arthritis	☐	☐
Joint/Muscle Pain	☐	☐
Chronic Back Pain	☐	☐
NEUROLOGIC		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
RESPIRATORY		
Asthma	☐	☐
Emphysema	☐	☐
Chronic Bronchitis	☐	☐
Sinus Congestion	☐	☐
Dry Throat/Mouth	☐	☐
PSYCHIATRIC		
Anxiety	☐	☐
Depression	☐	☐
Emotional/Psychological	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

Medical Doctor _____ **Height** _____ **Weight** _____

Pharmacy _____

Do you have any allergies to medication? No ☐ Yes ☐ If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Social History:

Do you smoke? No ☐ Yes ☐ Have you ever smoked? No ☐ Yes ☐ If yes, when did you quit? _____

Do you use alcohol? No ☐ Yes ☐

Do you use recreational drugs? No ☐ Yes ☐