

Dr. Michael J. Vaske & Assoc.

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Patient's Name: First _____ Last _____ M.I. _____

Name of Parent/Guardian (if minor) _____ Nicknames _____

Date of Birth: ___/___/___ Age: ___ Gender: M / F Marital Status: Single Married Other

Home Address: _____ City: _____ State: ___ Zip: _____

Telephone: Home _____ Mobile _____ Work _____ ext. _____

Occupation: _____ E-mail: _____

Medical History

Last Eye Exam: ___/___/___ Reason for today's visit: _____

Who is your family doctor? _____

List medications you are currently taking: _____

Do you wear glasses? Yes No Full Time Part Time Distance Only Reading Only

Do you wear contact lenses? Yes No Contact lens type/or brand: _____

Contact lens disinfection type: _____

If no, are you interested in contact lenses? Yes No

List any of the following that YOU have had: LASIK/RK/PRK, lazy eye, glaucoma, cataract(s), cataract(s) removed, glaucoma, Retinal disease, Surgeries on eyes, Flashes/Floaters, Sandy, Gritty eyes, etc: _____

List medications or substances you have allergies to: _____

Females only: Are you pregnant? Yes No Nursing? Yes No

Family History

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

Glaucoma _____

Macular Degeneration _____

Retinal Detachments/Disease _____

Cataract _____

Blindness _____

Cross eyes _____

Diabetes _____

High blood pressure _____

Cancer _____

Thyroid Disease _____

Arthritis _____

Review of Systems

Do you currently have any problems in the following areas? (Circle the condition(s) that applies)

Constitutional

Fever, Weight Loss/Gain, Insomnia

Ear, Nose, Mouth, Throat

Sinus congestion, Cough, Bloody nose, Dry throat,

Decrease in hearing, earache, hearing loss

Cardiovascular

High blood pressure, High cholesterol, Diabetes,

Heart disease, Arrhythmia, Pacemaker

Respiratory

Asthma, Bronchitis, Emphysema, Lung Cancer

Gastrointestinal

Chronic Diarrhea, GERD, Heartburn

Genitourinary

Menopause, Frequent urination

Musculoskeletal

Rheumatoid Arthritis, Osteo Arthritis, Fibromyalgia

Integumentary

Eczema, Psoriasis, Lumps

Neurological

Headaches, Migraines, Dizziness/Vertigo, Epilepsy

Psychiatric

Anxiety, Depression, Dementia

Endocrine

Thyroid (low/high), Diabetes, Lupus

Lymphatic

Anemia, Leukemia, Bleeding problems

Allergic/Immunologic

Seasonal allergies, Hay fever

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