Davich Vision Center

Patient Information:

Last Name _____First Name _____MI_____ Mr. Mrs. Ms. Rev. Dr.

DOB_____

Last 4 Digits of Social Security No. XXXX-XX-_____

Address _____ _____City_____ __State _____ Zip_____

Phone Number _____ Work Phone _____

Email Address_____

Emergency Contact Information:

Name_____ Relationship_____ Phone Number_____

Insurance Information:

Check which apply

Type of Insurance ☐ Vision ☐ Medical ☐None

Name of Insurance _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other_____

Medical Information:

Who is your family Physician?_____ Location _____

List any medications or eye drops you are allergic to:_____

List of current medications_____

_____

Are you Pregnant or Nursing? Yes / No

General Health History:

Check which apply

Do you wear glasses? ☐Yes ☐No Do you wear contact lenses? ☐Yes ☐No

Allergic/Immunologic
- ☐ Drug allergy
- ☐ Environmental allergy
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Other

Ears, Nose, Mouth
- ☐ Upper resp. tract infect
- ☐ Other

Gastrointestinal
- ☐ Crohn's
- ☐ Colitits
- ☐ Ulcer
- ☐ Digestive
- ☐ Other

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other

Psychiatric
- ☐ Depression
- ☐ Panic disorder
- ☐ Schizophrenia
- ☐ Other

Cardiovascular
- ☐ Heart disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular disease
- ☐ High Cholesterol
- ☐ Other

Endocrine
- ☐ Diabetes
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ Other

Genitourinary
- ☐ STD– viral herpetic, chlamydia
- ☐ Other

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ ankylosing spondylitis
- ☐ other

Respiratory
- ☐ Cigarette smoker
- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ other

Constitutional
- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other

Eyes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Surgery
- ☐ Other

Blood
- ☐ Anemia
- ☐ Large volume blood loss
- ☐ Leukemia
- ☐ Other

Neurological
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Other

- ☐ **Drugs** Yes/No
- ☐ **Alcohol** Yes/No

For Dr Use Only

☐ **Primary ROS taken today** ☐ **Reviewed** ____/____/____ **ROS today**
Changes Noted:

Intials:_____

Family History **Relation**
- ☐ Blindness _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Lazy Eye _____
- ☐ Retinal _____

PATIENT/GUARDIAN SIGNATURE_____ **Date**_____

How did you hear about us? Walk-In / Insurance / Facebook / Yelp / Google / Patient Referral_____ Other_____