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	Are you taking any medication?	Yes 🗆
ر	Patient Name	
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V		

SB	Sco	ottshluff	Vision Clinic	$ E \lambda \rangle $	
	Scottsbluff Vision Clinic EVV				
(Y`	Easte	rn Wyon	ning Eye Clinic		Patient I
					Patienti
		VISION INF	ORMATION		Are you
Date of last eye exam		Doctor		EYE	
Have you had eye surgery?			Yes □	□ No □	
DATE		EYE	PROCEDU	RE	
					OTHE
			H INFORMATION		
Name of I	physicia	an			
			_		
City		State			
FA	MILY H	ISTORY – CH	IECK ANY THAT AP	PLY	
Father	- F N	10ther – M	Brother – B S	ister – S	
Grandfather – GF			Grandmother – C	M	

MEDICATIONS

R MEDICATIONS

Do you have any drug allergies?

GASTROINTESTINAL

Digestive/acid reflux

PSYCHIATRIC

EARS, NOSE & THROAT

GENINTOURINARY

Viral herpetic, chlamydia

Upper respiratory tract

Crohns

Colitis

Ulcer

Other

Other

infection

Other

Other

Depression

Panic Disorder

Schizophrenia

DRUG ALLERGIES

PURPOSE

PURPOSE

No □

No 🗆

Yes □

CONSTITUTIONAL

DERMATOLOGY

NEUROLOGICAL

Multiple sclerosis

Weight loss

Fever

Fatigue

Trauma

Other

Eczema

Rosacea

Psoriasis

Epilepsy

Other

Other

Developmental disability

	Glaucoma	
	Cataract	
	Macular degeneratio	
	Surgery	
	Inflammatory disorde	
	Other	
RESPIRATORY		
	Cigarette smoker	
	Asthma	
	Bronchitis	
	Emphysema	
	Other	
MUSKULOSKELETAL		
	Fibromyalgia	
	Muscular dystrophy	
	Osteoarthritis	
	Rheumatoid arthritis	

Other

Diabetes

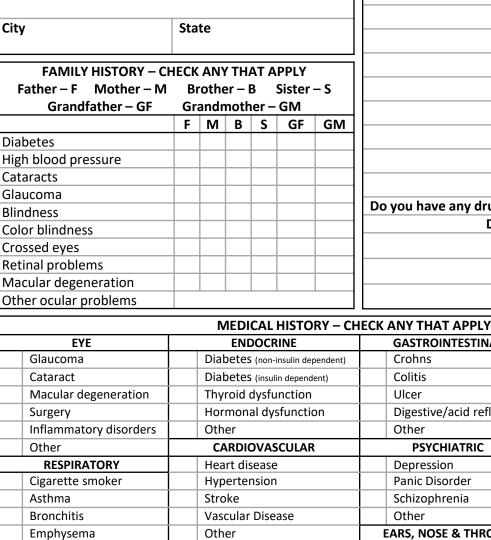
Cataracts Glaucoma

Blindness

Color blindness Crossed eyes **Retinal problems** Macular degeneration

High blood pressure

EYE



ALLERGIC/IMMUNOLOGIC

Environmental allergy

Rheumatoid arthritis

Drug allergy

Lupus

Other

HIV