## Sarah J Paikowsky, OD

## Eyes West Optical

Today's Date_______________

Welcome to our office. The information you complete here will allow us to give you better care:

**Name: Last** _______________ **First** _______________ MI______ **DOB**_____/_____/______

**Address:** _______________ city_______________ state__________zip__________

**Phone:** home(    ) _____ - ______ cell(    ) _____ - ______ **email**_______________ ☐

**Vision** Plan _______________ **Medical** Insurance _______________

**Language Preference**_______________ **Race** __________ **Ethnicity:** Hispanic___Latino___Other_____

**Please circle all that apply to you:** **Physician:** _______________

| **General** | **Psychological** | **Gastrointestinal** | **Skin/Integument** |
|---|---|---|---|
| Developmental Disabilities | ADD | Ulcer | Eczema |
| Cancer __________ | Bipolar | Celiac | Herpes Zoster/Shingles |
| Fatigue | Depression | Crohns | Herpes Simplex/Cold Sores |
| | Anxiety | Colitis | Rosacea |
| **Ear, Nose & Throat** | | Acid Reflux | Psoriasis |
| Laryngitis | **Cardiovascular** | | |
| Sinusitis | Congestive Heart Failure | **GYN/Urinary** | **Endocrine** |
| Dry Mouth | Hypertension | Nursing | Thyroid |
| Hearing Loss | Heart Disease | Pregnant<br>Trimester: 1 2 3 | Diabetes:<br>Type 1 Type 2 |
| | Vasculitis | STD | |
| **Neurology** | | Prostate Disease | **Hematology/Lymph** |
| Cerebral Palsey | **Respiratory** | Kidney | High Cholesterol |
| Epilepsy | Asthma | | Anemia |
| Migraines | Sleep apnea | **Muscular/Skeletal** | |
| Tumors__________ | Emphysema | Osteoporosis | **Allergy/Immunology** |
| Multiple Sclerosis | Bronchitis | Arthritis/Osteoarthritis | Lupus |
| Stroke/CVA | COPD | Muscular Dystrophy | Sjogren's Syndrome |
| | | Gout | Rheumatoid Arthritis |
| | | Ankyslosing Spondylitis | |
| | | Fibromyalgia | |

***** **Please turn page over to finish** *****

**\Please list your current medications.**

| *Drug Name* | *Dose* | *Taken how often?* | *Reason?* |
|---|---|---|---|
| | | | |
| | | | |
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Drug, Food, or Seasonal Allergies: Yes ____ No ______ If yes, please list ______________________________

____________________________________________________________________________________

**OCULAR HISTORY: Please circle S or F.** **S** = Self **F** = Family member **Mark all that apply.**

**S/F** Nystagmus

**S/F** Eye Injury

**S/F** Dry Eye

**S/F** Keratoconus

**S/F** Retinal Hole/Detachment

**S/F** Glaucoma **S/F** Glaucoma Suspect

**S/F** Cataract

**S/F** Macular Degeneration

**S/F** Eye Turn/Strabismus

**S/F** Lazy Eye/Amblyopia

**S/F** Eye Surgery Dates: _______

**S/F** Other: ______________

**FAMILY MEDICAL HISTORY: Mark all that apply to a close blood relative.**

Cancer Who:________________

Thyroid Who:________________

Hypertension Who:________________

Diabetes Who:________________

**SOCIAL HISTORY:**

Alcohol Use: **No** **Yes** If yes, #______ drinks per day/ week/ month

Tobacco Use: **N**ever Former Current: How often: every day /some days How much: heavy/light

Type: cigarette/ cigar/ pipe/ smokeless/other

*If former tobacco user, how many years ago did you quit?* ___________