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 Trimester: 1 2 3	Diabetes: 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?*

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 Retinal Hole/Detachment
S/F Eye Turn/Strabismus
S/F Eye Injury
S/F Glaucoma **S/F** Glaucoma Suspect
S/F Lazy Eye/Amblyopia
S/F Dry Eye
S/F Cataract
S/F Eye Surgery Dates: _______
S/F Keratoconus
S/F Macular Degeneration
S/F Other: ______________

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

Cancer Who:________________ Hypertension Who:________________

Thyroid Who:________________ Diabetes Who:________________

SOCIAL HISTORY:

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

Tobacco Use: **Never** **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? ___________

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