Dr. **James** P. DeVleming

Pullman Vision Source™

Name: _____

Today's Date: _____

Medical History

Do you have any allergies to medications? ❑ No ❑ Yes If yes, please list _____

Do you have any environmental allergies? ❑ No ❑ Yes

List all medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies).

_____

List major injuries, surgeries, and/or hospitalizations you have had:

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, eye infection, glaucoma, cataracts or macular degeneration

_____

Do you now or have you ever experienced problems in the following areas? Please check all that apply.

System

Constitutional
Fever/Weight loss/Gain ❑ No ❑ Yes

Integumentary

Eczema ❑ No ❑ Yes
Psoriasis ❑ No ❑ Yes
Cancer ❑ No ❑ Yes

Neurological

Headaches ❑ No ❑ Yes
Migraines ❑ No ❑ Yes
Seizures ❑ No ❑ Yes
Multiple Sclerosis ❑ No ❑ Yes
Cancer ❑ No ❑ Yes

Ear/Nose/Throat

Allergies/Hay Fever ❑ No ❑ Yes
Sinus Congestion ❑ No ❑ Yes
Chronic Cough ❑ No ❑ Yes
Dry Throat/Mouth ❑ No ❑ Yes

Endocrine

Non-insulin Dependent Diabetes ❑ No ❑ Yes
Insulin Dependent Diabetes ❑ No ❑ Yes
Thyroid Dysfunction ❑ No ❑ Yes
Hormonal Dysfunction ❑ No ❑ Yes

Respiratory

Asthma ❑ No ❑ Yes
Chronic Bronchitis ❑ No ❑ Yes
Emphysema ❑ No ❑ Yes
Cancer ❑ No ❑ Yes

Vascular/Cardiovascular

High Blood Pressure ❑ No ❑ Yes
High Cholesterol ❑ No ❑ Yes
Stroke ❑ No ❑ Yes
Heart Disease ❑ No ❑ Yes

Gastreointestinal

Crohn's ❑ No ❑ Yes
Colitis ❑ No ❑ Yes
Ulcer ❑ No ❑ Yes
Digestive ❑ No ❑ Yes

Genitourinary

Genitals/Kidney/Bladder ❑ No ❑ Yes

Lymphatic/Hematologial

Bleeding Problems ❑ No ❑ Yes

Psychiatric

Depression ❑ No ❑ Yes
Panic Disorder ❑ No ❑ Yes
Schizophrenia ❑ No ❑ Yes

Pregnant/Nursing ❑ No ❑ Yes

Have you ever had any of the following conditions involving your eyes or do you experience?

❑ Eye surgery (type/date _____) ❑ Double Vision ❑ Eye Injury _____
❑ Floaters ❑ Flashes ❑ Other _____

Please Check Eye Symptoms You Experience:

❑ Dry Eye Feeling ❑ Tearing/Watery Eyes ❑ Foreign Body Sensation
❑ Burning ❑ Mucous Discharge ❑ Fluctuating Visual Acuity
❑ Itching ❑ Redness ❑ Tired Eyes
❑ Pain or Soreness ❑ Chronic Infection ❑ Frequent Headaches
❑ Sandy or Gritty Feeling ❑ Sties, Chalazion ❑ Light Sensitivity

Social History

Occupation: _____
Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving ❑ No ❑Yes

If yes, please describe _____
Do you smoke? ❑ No ❑ Yes Packs per day? _____
If former smoker, how long ago did you quit? _____
Do you drink alcohol? ❑ No ❑ Yes If yes, amount? _____
Do you use recreational drugs? ❑ No ❑ Yes If yes, type/amount/how long? _____
Have you been exposed to or infected with HIV ❑ No ❑ Yes Any other Sexually Transmitted Disease? ❑ No ❑ Yes

Hobbies/Recreation/Sport - Please mark the boxes that most accurately apply to you. ❑ Boating/fishing ❑ Gardening ❑ Photography ❑ Sewing
❑ Card playing ❑ Golf ❑ Racquetball/Handball ❑ Flying ❑ Swimming/Scuba Diving ❑ Crafts ❑ Hunting ❑ Skiing ❑ Music

Do you wear glasses? ❑ No ❑ Yes Dominant hand ❑ Right ❑ Left
Do you wear contact lenses? ❑ No ❑ Yes
Type of contact lenses? ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other _____ Are they comfortable? ❑ No ❑ Yes
How often do you replace your contacts? ❑ Daily ❑ 1-2Weeks ❑ Monthy ❑ Quarterly ❑ Yearly ❑ Other _____
What brand of contacts do you wear? _____