Hussey Eyecare

VISION SOURCE

480 Old Smizer Mill Road ● Fenton MO 63026
Phone: (636) 305-7110 ● Fax: (636) 305-9509 ● www.scotthusseyod.com

Today's Date _____

Last Name_____ First Name_____ MI_____ Preferred Name _____
Address_____ City_____ State_____ Zip Code_____
Preferred Number: Home _____ Work _____ Cell _____
Date of Birth _____SSN _____Email_____ Employer _____
Whom may we thank for your referral to our office?
_____
Race and Ethnicity: Preferred Language:_____
□ Unknown □ African American □ American Indian □ Arab □ Asian □ Indian Gender: □ Male □ Female
□ Hispanic or Latino □ Not Hispanic or Latino □ Hawaiian □ Multiracial □ Caucasian

Medical Information

What is your general health? _____Height_____ Weight_____
Do you have problems with any of these systems? (**Please circle yes or No)**

Ears/Nose/Throat	□YES □NO	High Blood Pressure	□YES □NO	Integumentary (skin)	□YES □NO
Neurological	□YES □NO	Respiratory	□YES □NO	Endocrine/Diabetes	□YES □NO
Headaches	□YES □NO	Gastrointestinal	□YES □NO	Blood/Lymph	□YES □NO
Psychiatric	□YES □NO	Urinary	□YES □NO	Allergic/Immunologic	□YES □NO
Cardiovascular	□YES □NO	Muscles/Bones	□YES □NO	Pregnant	□YES □NO
Please Explain _____				Nursing	□YES □NO

Diabetes □YES □NO Type_____ Date of diagnosis_____ _____
Allergies to medication □YES □NO Which ? _____
Current Medication(s) _____
Have you had any operations □YES □NO Type _____ When _____
Name of Family Doctor _____
Last Eyecare Provider _____ Date of last exam _____
Preferred Pharmacy _____ Location _____
Smoking History Do you drink alcohol □YES □NO _____
□ Current Everyday Smoker Do you use illegal drugs □YES □NO _____
□ Current Occasional Smoker Have you ever been exposed to or infected with: □HIV □Hepatitis
□ Former Smoker
□ Non Smoker

Family History

Macular Degeneration	□YES □NO Relation _____	High Blood Pressure	□YES □NO Relation _____
Retinal Detachment	□YES □NO Relation _____	Diabetes	□YES □NO Relation _____
Glaucoma	□YES □NO Relation _____	Cancer	□YES □NO Relation _____

Personal Eye Information

Do you have any eye conditions or problems? □YES □NO What kind?_____ _____
Have you had any eye operations? □YES □NO Type _____ Date _____
Have you had an eye injury? □YES □NO Type _____ Date _____

Do you have Glaucoma	□YES □NO	Cataracts	□YES □NO	Dry/Red/Gritty Eyes	□YES□NO
Macular Degeneration	□YES □NO	Retinal Detachment	□YES □NO	Blurred Vision	□YES □NO
Do you wear Glasses	□YES □NO	Contact Lenses	□YES □NO	Type _____	

Interested in Lasik? _____