# Hussey Eyecare

VISION SOURCE

www.scotthusseyod.com

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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
□ Current Everyday Smoker □ Former Smoker
□ Current Occasional Smoker □ Non Smoker
Do you drink alcohol □YES □NO _____
Do you use illegal drugs □YES □NO_____

## Family History

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