KALKASKA
family vision Care

Welcome to our office!

Clayton G. Skrzypczak, O.D.

Date: _____

Name: _____ DOB: _____ Age: _____

Mailing Address: _____ SS # (last 4): _____

City: _____ State: _____ Zip Code: _____

Spouse/Parent if under 18 _____ Home Telephone: _____

Patient's Occupation: _____ Cell Telephone: _____

e-mail: _____ ***PLEASE CIRCLE PREFERRED CONTACT NUMBER***

Primary Care Dr: _____

Local Pharmacy: (name/location) _____

Mail Order Pharmacy: _____

Insurance Information: Vision: _____ Medical: _____

Insurance subscriber's name, date of birth & last 4 SS# (if different from patient): (Primary Cardholder)

_____

Do you wear Contact Lenses? ❑ Yes ❑ No Are you interested in wearing Contact Lenses? ❑ Yes ❑ No

What type/brand of Contact Lenses do you wear? _____

EYE MEDICATIONS: (Please list all)

Medication Name	Dosage

Eye Vitamins (AREDS, Macular Degen.) ❑ Yes ❑ No Artificial Tears ❑ Yes ❑ No

OTHER MEDICATIONS: (Please list all)

Medication Name	Strength	Dosage

Aspirin? ❑ Yes ❑ No Insulin? ❑ Yes ❑ No Ever used Flomax or other prostate med? ❑ Yes ❑ No

Height: _____ Weight: _____ Blood Pressure: _____

If female, are you currently pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

ALLERGIES: (Please list your allergies) ❑ No Known Allergies Latex (allergy or sensitivity) ❑ Yes ❑ No

Allergy	Reaction

PAST EYE HISTORY/EYE SURGERY	YEAR

LIST YOUR PAST MEDICAL DIAGNOSES

_____

_____

_____

Diabetes: Type _____	❑ Yes ❑ No	COPD or Emphysema	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Cancer: Type _____	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No		

PAST SURGERIES	**YEAR**
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY OF EYE DISEASE		**FAMILY MEMBER** (If Yes)
Glaucoma	❑ Yes ❑ No	_____
Macular Degeneration	❑ Yes ❑ No	_____
Strabismus or Lazy Eye	❑ Yes ❑ No	_____

REVIEW OF SYSTEMS: Check every symptom that you have **TODAY**

Constitutional:		Musculoskeletal:		Head (HEENT):	
Fever	❑ Yes	Muscle Cramping	❑ Yes	Sinus Problems	❑ Yes
Weight Loss	❑ Yes	Muscle Weakness	❑ Yes	Sore Throat	❑ Yes
Respiratory:		Psychiatric:		Integumentary/Skin:	
Cough	❑ Yes	Depressed Mood	❑ Yes	Rash	❑ Yes
Shortness of Breath	❑ Yes	Emotional Changes	❑ Yes	Ulcer	❑ Yes
Gastrointestinal:		Hematological/Lymphatic:		Immunologic:	
Abdominal Pain	❑ Yes	Bleeding	❑ Yes	Food Allergies	❑ Yes
Nausea	❑ Yes	Tender Lymph Nodes	❑ Yes	Seasonal Allergies	❑ Yes

Cardiovascular:		Neurological:	
Arrhythmia (heart rhythm problem)	❑ Yes	Dizziness	❑ Yes
Irregular heart beat/palpitations	❑ Yes	Numbness of extremities	❑ Yes
Genitourinary:		Metabolic/Endocrine:	
Painful Urination (Dysuria)	❑ Yes	Heat Intolerance	❑ Yes
Sudden Urge to Urinate (Urgency)	❑ Yes	Frequent Drinking/Thirst (Polydipsia)	❑ Yes

SOCIAL HISTORY:

Have you ever used tobacco? ❑ Yes ❑ No/Never ❑ Unknown

Smoking Status:

- ❑ Never Smoked
- ❑ Former Smoker
- ❑ Current every-day smoker
- ❑ Current some-day smoker

Non-Smoking Tobacco Use (chew/snuff/dipping):

- ❑ Never Used
- ❑ Ex-user of chew/snuff/dip
- ❑ Chews tobacco
- ❑ Snuff user