Scottsbluff Vision Clinic
Eastern Wyoming Eye Clinic

Patient Name_____

VISION INFORMATION

Date of last eye exam	Doctor

Have you had eye surgery? Yes ☐ No ☐

DATE	EYE	PROCEDURE

GENERAL HEALTH INFORMATION

Name of physician	
City	**State**

FAMILY HISTORY – CHECK ANY THAT APPLY

Father – F Mother – M Brother – B Sister – S
Grandfather – GF Grandmother – GM

	F	M	B	S	GF	GM
Diabetes						
High blood pressure						
Cataracts						
Glaucoma						
Blindness						
Color blindness						
Crossed eyes						
Retinal problems						
Macular degeneration						
Other ocular problems						

Are you taking any medication? Yes ☐ No ☐

EYE MEDICATIONS	PURPOSE
OTHER MEDICATIONS	**PURPOSE**

Do you have any drug allergies? Yes ☐ No ☐

DRUG ALLERGIES

MEDICAL HISTORY – CHECK ANY THAT APPLY

EYE	ENDOCRINE	GASTROINTESTINAL	CONSTITUTIONAL
☐ Glaucoma	☐ Diabetes (non-insulin dependent)	☐ Crohns	☐ Developmental disability
☐ Cataract	☐ Diabetes (insulin dependent)	☐ Colitis	☐ Weight loss
☐ Macular degeneration	☐ Thyroid dysfunction	☐ Ulcer	☐ Fever
☐ Surgery	☐ Hormonal dysfunction	☐ Digestive/acid reflux	☐ Fatigue
☐ Inflammatory disorders	☐ Other	☐ Other	☐ Trauma
☐ Other	**CARDIOVASCULAR**	**PSYCHIATRIC**	☐ Other
RESPIRATORY	☐ Heart disease	☐ Depression	**DERMATOLOGY**
☐ Cigarette smoker	☐ Hypertension	☐ Panic Disorder	☐ Eczema
☐ Asthma	☐ Stroke	☐ Schizophrenia	☐ Rosacea
☐ Bronchitis	☐ Vascular Disease	☐ Other	☐ Psoriasis
☐ Emphysema	☐ Other	**EARS, NOSE & THROAT**	☐ Other
☐ Other	**ALLERGIC/IMMUNOLOGIC**	☐ Upper respiratory tract infection	**NEUROLOGICAL**
MUSKULOSKELETAL	☐ Drug allergy		☐ Multiple sclerosis
☐ Fibromyalgia	☐ Environmental allergy	☐ Other	☐ Epilepsy
☐ Muscular dystrophy	☐ Rheumatoid arthritis	**GENINTOURINARY**	☐ Other
☐ Osteoarthritis	☐ Lupus	☐ STD	
☐ Rheumatoid arthritis	☐ HIV	☐ Viral herpetic, chlamydia	
☐ Other	☐ Other	☐ Other	