TOWN CENTER VISION
James W. Freshwater, O.D. & Timothy C. Jameson, O.D.

SSN:_____ If a minor, the insured's SSN:_____
Patient Name:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____
Day Time Number:_____ Cell Phone:_____ Work:_____
E-mail address:_____

_____
Referred by:_____ Family Physician:_____
Employer:_____ Occupation:_____
List of Medications:_____

_____

_____
List any allergies to medications or substances:_____

_____
List of any surgeries:_____
Last eye exam date:_____ Age of present glasses:_____
Have you ever worn contact lenses?_____ Do you currently wear them?_____

Family History: **(Mother, Father, Grandparent, Sibling)**
Are there any inherited diseases such as Diabetes, Blindness, Glaucoma, Cataracts, Macular Degeneration, Cancer, Thyroid Disease and High Blood Pressure?

_____

_____

Review of Medical Systems: **Normal**
Do you currently have any problems in the following areas? If yes, please describe:
Eyes (poor vision, eye pain, redness, cataracts, glaucoma)

_____ _____
Ear, Nose & Throat (hard of hearing, stuffy nose, earache, cough)

_____ _____
Cardiovascular (High BP, high pulse)_____ _____
Respiratory (shortness of breath, congestion, asthma)

_____ _____
Gastrointestinal (ulcers, hernia)_____ _____
Musculoskeletal (arthritis, swelling, osteoporosis)

_____ _____
Skin/Breast (skin cancer, eczema, breast cancer)

_____ _____
Neurological (migraines, seizures, headaches)_____ _____
Psychiatric (anxiety, depression, insomnia)

_____ _____
Endocrine (Diabetes, thyroid disease)_____ _____
Hematologic(anemia, high cholesterol, bleeding disorder)

_____ _____
Allergic/Immunologic (allergies, hives, lupus, swelling)

_____ _____

Social History: (For patients 13 and older)
Have you ever had a blood transfusion? **YES NO**
Do you use alcohol? **YES NO** If **YES**, how much?_____
Do you smoke? **YES NO** If **YES,** how much?_____ How many years?_____

Patient Signature_____ Date:_____