

Baier Family Optometry ♦ Craig W. Baier, O.D.

515 N. Main, Newton, KS 67114 (316)283-2112

Patient Name: _____ E-mail: _____ (you give authorization)	Please check any current eye problems:																																																																											
Check Any Current Health Problems	<table style="width: 100%;"> <tr><td>Eye Pain</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Loss of Vision</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Blurred Vision</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Distorted Vision</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Double Vision</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Dryness</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Redness</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Mucous</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Watering</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Itching/Burning</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Flashes of Light</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Floater</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Cataracts</td><td style="text-align: right;"><input type="checkbox"/></td></tr> <tr><td>Glaucoma</td><td style="text-align: right;"><input type="checkbox"/></td></tr> </table>	Eye Pain	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Distorted Vision	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	Redness	<input type="checkbox"/>	Mucous	<input type="checkbox"/>	Watering	<input type="checkbox"/>	Itching/Burning	<input type="checkbox"/>	Flashes of Light	<input type="checkbox"/>	Floater	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>																																															
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	Are you pregnant or nursing? ___yes ___no Are you under the care of a Dr.? ___yes ___no Dr.'s Name: _____ Reason: _____																																																																											

Patient's Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

___ Yes, I would prefer to discuss my Social History information directly with the doctor.

Do you use tobacco products? ___yes ___no

Do you consume alcohol? ___yes ___no

Have you ever had or been treated for: ___Gonorrhea

___Hepatitis ___HIV/Aids ___Syphilis

Do you use illegal narcotics? ___yes ___no

Current Medications/Supplements

Name of Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History

Please note any family history (blood relatives-not you) living or deceased.

	Relationship
___ Blindness	_____
___ Cataracts	_____
___ Glaucoma	_____
___ Macular Degeneration	_____
___ Retinal Detachment	_____
___ Crossed Eyes	_____
___ Diabetes	_____
___ High Blood Pressure	_____
___ Thyroid Disease	_____

List any medications you are allergic to:

I have completed the information to the best of my knowledge.

Website

Patient's Signature

Date