Vision Source™

WELCOME TO OUR OFFICE

Patient Information

Last Name________________________________

First Name _______________________M_____

Street Address____________________________

City_________________ Zip Code___________

Date of Birth______________________________

Gender: Male Female Age______________

Marital Status: Single / Married / Divorced / Other

Home Phone______________________________

Cell Phone _______________________________

Work Phone______________________________

Email ____________________________________

Occupation (or Grade) _____________________

Employer (or School) ______________________

Spouse (or Parent's) Name________________

Insurance Information

Subscriber's Name: ______________________

Subscriber's DOB: _______________________

Review of Systems

Please check all that apply:

Cardiovascular
- ❑ High Cholesterol
- ❑ Heart Attack
- ❑ Low/High Blood Pressure
- ❑ Murmur
- ❑ Other:_____________________________

Constitutional
- ❑ Fatigue
- ❑ Malaise
- ❑ Fever
- ❑ Weight Changes
- ❑ Other: _____________________________

Endocrine
- ❑ Hypothyroid
- ❑ Diabetes
- ❑ Hot/Cold Intolerance
- ❑ Hyperthyroid
- ❑ Other: _____________________________

Gastrointestinal
- ❑ Acid Reflux
- ❑ Indigestion
- ❑ Nausea/Vomiting
- ❑ Heartburn
- ❑ Other: _____________________________

Genitourinary
- ❑ Enlarged Prostate
- ❑ Kidney Stones
- ❑ Incontinence
- ❑ Difficulty Urinating
- ❑ Frequent UTI's
- ❑ Other:

HEENT
- ❑ Head injury
- ❑ Earache
- ❑ Decreased Hearing
- ❑ Sinus Pain
- ❑ Seasonal Allergies
- ❑ Difficulty Swallowing
- ❑ Other:_____________________________

Hematologic
- ❑ Ease of bruising
- ❑ Excessive bleeding
- ❑ Anemia
- ❑ Cancer (Any)
- ❑ Other: _____________________________

Dermatological
- ❑ Rash
- ❑ Lump
- ❑ Itching
- ❑ Dryness
- ❑ Other: _____________________________

Musculoskeletal
- ❑ Arthritis
- ❑ Muscle weakness
- ❑ Back/ Joint Pain
- ❑ Stiffness
- ❑ Other: _____________________________

Neurological
- ❑ Alzheimer's
- ❑ Stroke
- ❑ Migraines
- ❑ Tremors
- ❑ Multiple Sclerosis
- ❑ Seizures
- ❑ Other: _____________________________

Psychiatric
- ❑ Depression
- ❑ Memory Loss
- ❑ Panic Attacks
- ❑ Bipolar
- ❑ Anxiety
- ❑ Schizophrenia
- ❑ Other:_____________________________

Respiratory
- ❑ COPD
- ❑ Shortness of breath
- ❑ Pneumonia
- ❑ Chronic Bronchitis
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Other: _____________________________
- ❑ **NONE OF THE ABOVE**

Primary Care Provider:

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Medications

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Medication Allergies:

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How did you hear about us?

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X____

Patient Signature/Parent if minor Date