Offices of Dr. David Epp

104 E. Main, Sayre, OK 73662 * 117 E. 3rd, Shamrock, TX 79079

Full Name_____ Parent's Name or Responsible Party_____

Mailing Address_____ City/State/Zip_____

Home Phone_____ E-Mail_____

Cell Phone_____ Is it OK to text you with appt. reminders?_____

Preferred Name_____ Preferred Mode of Contact: Home Cell E-Mail

Sex: Male Female DOB ____ /_____ /_____ SSN_____

Occupation_____ Employer_____ Work Phone_____

Marital Status: S M D W Spouse Name_____ Spouse Phone_____

Insurance Company:_____ Insured's Name_____

Insured's Address_____

City/State/Zip_____ Relationship to Patient_____

Insured's SS#_____ Insured's DOB ____ /_____ /_____

Please answer the following questions about your health. While this information is not required, it helps the doctor see a picture of your overall health and how that may affect your vision. If you have a list of medications or surgeries, you may give the list to the receptionist instead of copying it onto our form. **Check all that apply:**

Cardiovascular
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Stroke
- ☐ Other_____

Constitutional
- ☐ Dizziness/fainting
- ☐ Unexplained weight change
- ☐ Appetite change
- ☐ Other_____

Endocrine
- ☐ Diabetes (Type 1, 2, or borderline)
- ☐ Thyroid
- ☐ Kidney disease
- ☐ Hypoglycemia
- ☐ Gout
- ☐ Other_____

Gastrointestinal
- ☐ Acid reflux
- ☐ Liver disease
- ☐ Stomach ulcers
- ☐ Irritable bowel syndrome
- ☐ Diverticulosis
- ☐ Other_____

Genitourinary
- ☐ Bladder disorder
- ☐ Prostate disease
- ☐ Menopause
- ☐ Ovarian/Uterine disease
- ☐ Other_____

Head
- ☐ Dry mouth
- ☐ Headaches/migraine
- ☐ Hearing loss
- ☐ Sinus disorder
- ☐ Other_____

Hematologic/Lymphatic
- ☐ Blood disorder
- ☐ Anemia
- ☐ Lymph node disease
- ☐ Other_____

Immunologic
- ☐ AIDS/HIV
- ☐ Herpes simplex
- ☐ Shingles
- ☐ Lupus
- ☐ Other_____

Integumentary
- ☐ Acne rosacea
- ☐ Dry skin
- ☐ Skin cancer
- ☐ Other_____

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Myasthenia gravis
- ☐ Spine disorder
- ☐ Other_____

Neurological
- ☐ Bell's Palsy
- ☐ Brain cancer/disease
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Seizure disorder
- ☐ Parkinson's
- ☐ Other_____

Psychiatric
- ☐ Depression/Mood disorder
- ☐ ADD/ADHD
- ☐ Alzheimer's/Dementia
- ☐ Autism
- ☐ Bipolar
- ☐ Learning disability
- ☐ Other_____

Respiratory
- ☐ Asthma
- ☐ Lung cancer
- ☐ COPD
- ☐ Emphysema
- ☐ Other_____

Name of Family Doctor_____ Date of last visit_____

List any operations you have had and approximately when _____

_____

_____

List all medications (even over-the-counter) and what you take them for:

_____ for _____ _____ for _____

_____ for _____ _____ for _____

_____ for _____ _____ for _____

Allergies to medications_____

_____

Other Allergies_____

_____

Personal Eye History

Have you ever had cataract surgery? Y / N When? Right Eye _____ Left _____

Laser after cataract surgery? Y / N When? Right Eye _____ Left _____

Any other eye operations? Y / N _____

Any eye injuries? Y / N _____

Have you ever been told you have:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Macular Degeneration
- ☐ Eye Turn
- ☐ Lazy Eye
- ☐ Other Eye Disease _____

Do you wear: Glasses Y / N Date of last glasses?_____ Contacts? Y / N Brand_____

Date of last eye exam_____ Dr. _____

Family Eye History (parents, siblings, children, grandparents)

Glaucoma? Y / N Relation_____ Macular Degeneration? Y / N Relation_____

Cataracts? Y / N Relation_____ Retinal Detachment? Y / N Relation_____

Other Eye Conditions? Y / N Describe_____

Other Personal Health Information

Approximate Height_____ Approximate Weight_____

Alcohol Use (Circle One) None Social Use 1-2 drinks daily Above average use Alcohol Dependent

Smoking: None Current Smoker Former Smoker

Smokeless Tobacco: None Current User Former User

Narcotic Use: None Recreational Chemical Dependence

Sexually Transmitted Disease None Yes HIV Positive