

Offices of Dr. David Epp

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

Parent's Name or

High cholesterol	Full Name		Responsibl		
Cell Phone	Mailing Address		City/State	/Zip	
Preferred Name					
Preferred Name	Cell Phone		Is it OK to text you wi	th appt. remir	nders?
Sex: Male Female DOB / / SSN					
Coccupation					
Insured's Name	Sex: Male Female DOB	_//	/ SSN		
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 do your overall health and how that may affect your vision. If you have a list of medications or surgeries, you may receptionist instead of copying it onto our form. Check all that apply: Cardiovascular Genitourinary Musculoskeletal High blood pressure Bladder disorder Osteoarth High cholesterol Prostate disease Rheumate Heart disease Menopause Stroke Ovarian/Uterine disease Spine disc Other Other Other Bell's Pals Pals Unexplained weight Headaches/migraine Brain can change Head Readaches/migraine Brain can change Heart other Sinus disorder Bell's Pals Down Syr Appetite change Sinus disorder Brain can change Hematologic/Lymphatic Parkinson Other Seizure di Endocrine Hematologic/Lymphatic Parkinson Diabetes (Type 1, 2, or Blood disorder Other Seizure di Endocrine Hematologic (Lymphatic Parkinson Hypolycemia Lymph node disease Depression Gout AlDS/HIV Alzheimet Gastrointestinal Shingles Bipolar Bipolar Gastrointestinal Shingles Bipolar Alzheimet Gastrointestinal Shingles Bipolar Bipolar Caterious Asthma Diverticulosis Dry skin Lung cancel Asthma Diverticulosis Dry skin Lung cancel Character Asthma Diverticulosis Dry skin Lung cancel Character Asthma Dry skin Lung cancel Character Asthma Dry skin Lung cancel Character Characte	Occupation		Employer	Wo	ork Phone
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 do your overall health and how that may affect your vision. If you have a list of medications or surgeries, you may receptionist instead of copying it onto our form. Check all that apply: Cardiovascular Genitourinary Musculoskeletal High blood pressure Bladder disorder Osteoarth High cholesterol Prostate disease Rheumate Heart disease Menopause Stroke Ovarian/Uterine disease Spine disc Other Other Other Bell's Pals Pals Unexplained weight Headaches/migraine Brain can change Head Readaches/migraine Brain can change Heart other Sinus disorder Bell's Pals Down Syr Appetite change Sinus disorder Brain can change Hematologic/Lymphatic Parkinson Other Seizure di Endocrine Hematologic/Lymphatic Parkinson Diabetes (Type 1, 2, or Blood disorder Other Seizure di Endocrine Hematologic (Lymphatic Parkinson Hypolycemia Lymph node disease Depression Gout AlDS/HIV Alzheimet Gastrointestinal Shingles Bipolar Bipolar Gastrointestinal Shingles Bipolar Alzheimet Gastrointestinal Shingles Bipolar Bipolar Caterious Asthma Diverticulosis Dry skin Lung cancel Asthma Diverticulosis Dry skin Lung cancel Character Asthma Diverticulosis Dry skin Lung cancel Character Asthma Dry skin Lung cancel Character Asthma Dry skin Lung cancel Character Characte	Marital Status: S M D W Spouse	Name		Spouse Phon	e
City/State/Zip					
City/State/Zip	Insured's Address				
Please answer the following questions about your health. While this information is not required, it helps the do your overall health and how that may affect your vision. If you have a list of medications or surgeries, you may receptionist instead of copying it onto our form. Check all that apply: Cardiovascular					
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change	☐ High blood pressure ☐ High cholesterol ☐ Heart disease ☐ Stroke ☐ Other	 	Bladder disorder Prostate disease Menopause Ovarian/Uterine disease Other	 - - Neurolo	Osteoarthritis Rheumatoid arthritis Myasthenia gravis Spine disorder Other
□ Diabetes (Type 1, 2, or borderline) □ Blood disorder borderline □ Psychiatric □ Thyroid □ Lymph node disease □ Depression □ Kidney disease □ Other □ disorder □ Hypoglycemia Immunologic □ ADD/ADH □ Gout □ AIDS/HIV □ Alzheimer □ Other □ Herpes simplex □ Autism Gastrointestinal □ Shingles □ Bipolar □ Acid reflux □ Lupus □ Learning or control □ Liver disease □ Other □ Other □ Stomach ulcers Integumentary Respiratory □ Irritable bowel syndrome □ Acne rosacea □ Asthma □ Diverticulosis □ Dry skin □ Lung cancer	change ☐ Appetite change ☐ Other		Hearing loss Sinus disorder Other		Brain cancer/disease Down Syndrome Multiple Sclerosis Seizure disorder
Gastrointestinal □ Shingles □ Bipolar □ Acid reflux □ Lupus □ Cearning of Diverticulosis □ Stomach ulcers □ Other □ Other □ Irritable bowel syndrome □ Acne rosacea □ Asthma □ Diverticulosis □ Dry skin □ Lung cancer	Diabetes (Type 1, 2, or borderline) Thyroid Kidney disease Hypoglycemia Gout	 	Blood disorder Anemia Lymph node disease Other logic AIDS/HIV	Psychiat	Depression/Mood disorder ADD/ADHD Alzheimer's/Dementia
□ Other □ Skin cancer □ COPD □ Other □ Emphyser	Gastrointestinal	Integum	Shingles Lupus Otherentary Acne rosacea Dry skin Skin cancer	Respirat	Bipolar Learning disability Other tory Asthma Lung cancer

Name of Family Doctor	Date of last visit				
List any operations you have had and approximately when					
List all medications (even over-the-cou	ter) and what you take them for:				
for	for	for			
for	for for				
	for				
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	 ☐ Macular Degeneration ☐ Eye Turn ☐ Under Eye Disection	ease			
□ Dry Eyes	□ Lazy Eye				
	t glasses? Contacts? Y / N Brand				
	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_					
	r Personal Health Information				
	Approximate Weight Approximate Alcohol Do				
Alcohol Use (Circle One) None Social Smoking:	Jse 1-2 drinks daily Above average use Alcohol De None Current Smoker Former Smoker	penaen			
Smokeless Tobacco:	None Current User Former User				
Narcotic Use:	None Recreational Chemical Dependence	ce			
Sexually Transmitted Disease	None Yes HIV Positive				