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

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

Patient Name:___________________________
E-mail:_________________________________(you give authorization)

Check Any Current Health Problems

CONSTITUTIONAL:	Fever, Weight Loss/Gain	O
INTEGUMENTARY:	Skin rash/changing moles	O
NEUROLOGICAL:	Headaches	O
	Migraines	O
	Seizure/Stroke/Paralysis	O
ENDOCRINE:	Thyroid/Other Glands	O
	Diabetes	O
EARS,NOSE, MOUTH, THROAT:	Allergies/Hay Fever	O
	Sinus Congestion	O
	Chronic Cough	O
	Dry Throat/Mouth	O
RESPIRATORY:	Asthma	O
	Chronic Bronchitis	O
	Emphysema	O
	Wheeze/Short. of Breath	O
VASCULATURE/ CARDIOVASCULAR:	High Cholesterol	O
	Stroke	O
	High Blood Pressure	O
LYMPHATIC/HEMATOLOGIC:	Anemia	O
GENITOURINARY:	Genitals/Kidney/Bladder	O
BONES/JOINTS/MUSCLES:	Rheumatoid Arthritis	O
	Muscle/Joint Pain	O
IMMUNOLOGIC:	Lupus	O
	Immune Deficiencies	O
PSYCHIATRIC:	Depression/Anxiety	O

Please check any current eye problems:

Eye Pain	O
Loss of Vision	O
Blurred Vision	O
Distorted Vision	O
Double Vision	O
Dryness	O
Redness	O
Mucous	O
Watering	O
Itching/Burning	O
Flashes of Light	O
Floaters	O
Cataracts	O
Glaucoma	O

Other:

Please list any major injuries/surgeries/ and/or hospitalizations

____
____
____

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
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________
____________________.......	_______________________

List any medications you are allergic to:

____
____

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	________________

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

____________________________ ______________
Patient's Signature Date