TEKWANI VISION CENTER

Name _____ Date of Birth ____/____/_____
(First) (MI) (Last)

Address_____
(Street) (City) (State) (Zip)

Phone (Home)_____ (Cell)_____ Email_____

Primary Care Physician _____ Phone # _____

Pharmacy name and phone number_____

Do you have now, or have you ever had any of the following?
Please circle any that apply to you.

PROBLEM

Decreased Hearing
Cancer
Type _____
Treatments_____
Angina
Heart Attack
High/Low Blood Pressure
High Cholesterol
Murmur
Thrombophlebitis
Varicose Veins
Congestive Heart Failure
Raynaud's Disease

COPD
Asthma
TB
Chronic Bronchitis
Sarcoidosis

Rosacea
Dermatitis
Psoriasis
Poison Ivy
Shingles
Affected Area _____
Eczema
Blepharitis

Hemorrhoids
Chron's Disease
Colitis
G.I. Cancer
Ulcer
Hiatus Hernia

BPH
Enlarged Prostate
Frequent UTIs
Incontinence
Kidney Stones
Renal Cancer

PROBLEM

Diabetes
Hypoglycemia
Goiter
Hypothyroidism
Hyperthyroidism

Alzheimer's
Epilepsy
Headaches
Migraines
MS
Neuropathy
Paralysis
Parkinson's Disease
Seizures

Stroke
TIAs
Tremor
Brain Tumor
TBI
Bell's Palsy

Depression
Mania
Anxiety
Panic Attacks
Past Suicide Attempts

Anemia
Lymphoma Leukemia
Hemophilia
Factor Deficiency
Disease

Rheumatoid Arthritis
Osteoarthritis
Lyme Disease
Muscular Dystrophy
Polymyalgia Rheumatica
Fibromyalgia

Do you currently use any eye medications (over the counter or prescription)?

□ Yes □ No
If yes, please list
_____
_____

Are there any other health issues we should be aware of? _____
_____

Are you allergic to anything that you know of?
□ Yes □ No
If yes, please list, _____

Please list all medications you take on a daily basis
_____
_____
_____
_____
_____
_____
_____

Do you have any **personal or family history** of any of the following;

	Self	**Family Relation**
Glaucoma	□	□ _____
Macular Degeneration	□	□ _____
Diabetes	□	□ _____
Retinal Disease	□	□ _____
Lazy Eye (or Eye Turn)	□	□ _____
Blindness	□	□ _____
Color Blind	□	□ _____
Light Sensitivity	□	□ _____
Dry Eyes	□	□ _____
Floaters	□	□ _____
Eye Injury	□	□ _____

Height _____
Weight _____