DV DURRIE VISION

Patient Information

Date _____

_____

Dr/Mr/Mrs/Ms/Miss First (legal name) Middle Last Suffix

Nickname _____ Date of Birth _____

_____

Street Address City State Zip

_____ _____ _____

Home Phone Daytime Phone Cell Phone

_____

Email address

May we contact you by email? ☐ Yes or ☐ No **(**please check) Sex: ☐ M or ☐ F **(**please check)

_____ _____

Employer Occupation/ Job Title

_____ _____

Emergency Contact Emergency Phone

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number_____

Durrie Vision, PA
8300 College Blvd – Suite 201 - Overland Park KS 6621
Phone - (913) 491-3330 Fax - (913) 491-9650

Health History

Medication History

Please list all medications you are currently taking, including the strength and dosage:

_____

_____

_____

Do you have a history of taking Flomax or similar medication for prostate issues?

☐ Yes or ☐ No (please check one) _____

Ocular History

Have you ever been diagnosed with any of the following eye problems? ☐ Yes or ☐ No, If so please include which eye, using R for right eye, L for left eye, and B for both eyes.

_____Amblyopia/Lazy Eye	_____Dry Eye	_____Iritis
_____Cataracts	_____Fuch's Dystrophy	_____Keratoconus
_____Corneal Scar	_____Glaucoma	_____Macular Degeneration
_____Diabetic Retinopathy	_____Injury/Trauma	_____Retinal Detachment/Tear

Other _____

Have you had any eye surgeries? ☐ Yes or ☐ No (please check one)

Surgery	Eye	Date	Doctor	Doctor's City/State
Cataract/Lens Replacement				
CK				
Corneal Transplant				
Lasik				
Lid Surgery				
LTK				
PRK				
RK				
Retinal Detachment and/or Repair				
Strabismus/Muscle Surgery				
Yag Laser				
Other				

Personal History

Have you ever been treated for any of the following medical conditions? (Check all that apply)

- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Back Problems
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cervical Fracture
- ☐ Depression
- ☐ Diabetes (insulin dependent)
- ☐ Diabetes (non-insulin dependent)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes Simplex
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Lupus
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Paraplegia
- ☐ Quadriplegia
- ☐ Rosacea
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ Other _____

Do you currently have any of the following?

- ☐ Cochlear Implants
- ☐ Internal Defibrillator
- ☐ Pacemaker

Are you currently pregnant? ☐ Yes or ☐ No (please check one)
Are you currently breastfeeding? ☐ Yes or ☐ No (please check one)
In the last 5 years, have you had any surgeries? ☐ Yes or ☐ No (please check one)
If so, please list and include date of surgery _____

_____

Patient Allergies

Please list all medications you are allergic to, and the reaction you experienced:

_____

_____

Are you allergic to any of the following? (If yes, please describe the reaction you experienced):
Check all that apply:

_____ Tape _____ _____ Latex _____ Iodine/Betadine

Family Medical History

Do any of your grandparents, parents, or siblings have any of the following? Check all the apply:

- ☐ Adopted
- ☐ Blindness
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Retinal Detachment or Disease
- ☐ Stroke
- ☐ Other _____

Social History

Do you drink? ☐ Yes or ☐ No (please check one) How Often? _____

Do you smoke? ☐ Yes or ☐ No (please check one) How Often? _____