



SISSON-BOYER EYECARE, LLC

W. Reynolds Sisson, O.D., F.A.A.O.
Kimberly Frantz Boyer, O.D.
Jeffrey Walter, O.D.

Name: _____ Date: _____

Address: _____ City: _____ ST: _____

Date of Birth: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Email Address: _____

Review of Systems: (please circle all that apply)

1. Constitution – Developmental Disabilities, Cancer, Fatigue Syndrome other: _____
2. Ear/Nose/Throat – Hearing Loss, Sinus Problems, Dry Mouth, Laryngitis other: _____
3. Neurological – MS, Epilepsy, Cerebral Palsy, Tumor, **Stroke**, Migraine other: _____
4. Psychiatric – Depression, Attention Deficit, Anxiety Disorder, Bipolar Disorder
other: _____
5. Cardiovascular – **High Blood Pressure** (hypertension), Heart Disease, Vascular Disease,
Congestive Heart Failure, **Heart attack** other: _____
6. Respiratory – Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep
Apnea other: _____
7. Gastro Intestinal – Crohn’s, Colitis, Ulcer, Acid Reflux, Celiac Disease other: _____
8. Genito-Urinary – Kidney Disease, Prostate Disease, Prostate Cancer, STD (Herpetic or
Chlamydia), Benign Prostate Hypertrophy, Pregnant/Nursing other: _____
9. Muscular/Skeletal – Arthritis, Oseosrthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing
Spondylitis, Osteoporosis, Gout other: _____
10. Dermatologic – Eczema, Rosacea, Psoriasis, Herpes Simplex (cold sore), Herpes Zoster (shingles)
other: _____
11. Endocrinology – **Type 2 Diabetes, Type 1 Diabetes, Thyroid Dysfunction**, Hormonal Dysfunction
other: _____
12. Hematological/Lymph – Anemia, Large Volume Blood Loss, Ulcer, High Cholesterol
other: _____
13. Allergy/Immunologic – Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus,
Sjogren’s Syndrome other: _____

Please list all medications: _____

Drug Allergies: _____ Primary Care Physician: _____

Please list previous ocular conditions: _____