VISION SOURCE®

SISSON-BOYER EYECARE, LLC

Kimberly Frantz Boyer, O.D.
Jeffrey Walter, O.D.

Name: _____ Date: _____

Address: _____ City: _____ Zip:_____

Date of Birth: _____Home Phone: _____Cell Phone: _____

Work Phone: _____ Email Address: _____

If under age 18, please list parent/guardian name: _____

Review of System: **(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, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing, Spondylitis, Osteoporosis, Gout Other: _____
10. Dermatologic – Eczema, Rosacea, Psoriasis, Herpes Simplex (Cold Sore), Herpes Zoster (Shingles)

    Other: _____
11. Endocrinology – **Type 1 Diabetes**, **Type 2 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: _____

Medication List:_____

Drug Allergies:_____Primary Care Physician:_____

Please list previous ocular conditions:_____