Peninsula Vision Care

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www.peninsulavisioncare.com

First Name:		Address:			Home:		
Last Name:		City:			Work:		
Middle Name:		State:			Cell:		
Nickname:		Zip:		Email:			
Date of Birth:	SSN:		Drinking:	Y / N	Amount:		
Sex: M / F / Other	Race:	Asian Black White Pacific Islander	Tobacco: Y / N Type: Amount:				
Right Handed/ Left Handed/ Ambidextrous		Latino Other	If yes, started: Quit:				
Marital Status:	Married to:		Last eye exam: Where:				
Occupation:			Glasses: Y / N Sunglasses: Y / N				
Parent Name (for minors):			For:				
Parent SSN (for minors):			Contacts: Y / N Type: Solution:				
Parent Date of Birth (for minors):			Replacement Schedule:				
Personal Ocular History: Any past con	nditions, inju	ries, surgeries, or problem	s with you	r eyes?			
Family History: Please indicate	•	•			O		
(Indicate F-Father, M-Mother, B-Brother, Sis-Sister, S-Son, D-I Cancer: Cataracts:			,				
Diabetes Type1:			Macular Degeneration:				
Diabetes Type2:		Glaucoma:					
Hypertension:		Retinal Detachments:					
Hyperthyroid:		Other:					
Hypothyroid:							
Primary Physician and Loca	ıtion:	<u> </u>					
Any allergies you may have?							
, , ,							

Musculoskeletal: None: ☐ Arthritis None:___ Constitution: ☐ Fibromyalgia ☐ Cancer Cardiovascular: None: ☐ Muscular Dystrophy ☐ High Blood Pressure ☐ Ankylosing Spondylitis ☐ Developmental Disability ☐ Weight Loss ☐ Stroke ☐ Gout ☐ Fever ☐ Heart Disease Comments:____ ☐ Fatigue ☐ Vascular Disease Trauma ☐ Congestive Heart Failure ☐ Headaches Comments:_____ Integumentary: None:____ ☐ Shortness of Breath ☐ Eczema ☐ Rosacea Comments:_____ ☐ Acne Respiratory: None:____ ☐ Smoking ☐ Psoriasis Ears, Nose, Throat: None:____ Asthma Cold Sores ☐ Hearing Loss ☐ Bronchitis ☐ Shingles Comments:____ ☐ Sinus Problems ☐ Emphysema □ COPD ☐ Dry Mouth ☐ Laryngitis ☐ Sleep Apnea Respiratory Tract Infection Comments:_____ None:_ Endocrine: ☐ Non-Insulin Dependent Diabetes Comments:____ ☐ Insulin Dependent Diabetes Gastrointestinal: None:____ ☐ Hyperthyroid Neurological: None:____ Crohn's Disease ☐ Hypothyroid ☐ Multiple Sclerosis ☐ Colitis ☐ Hormonal Changes High and low glucose #'s:_____ ☐ Epilepsy Ulcer Last A1c:____ ☐ Cerebral Palsy ☐ Acid Reflux Disease ☐ Celiac ☐ Tumor ☐ Stroke Comments:____ Hematologic/Lymphatic: None:____ ☐ TBI ☐ Anemia ☐ Migraines ☐ Leukemia Comments: None:____ ☐ Large Volume Blood Loss Genitourinary: ☐ Kidney Problems ☐ High Cholesterol ☐ Prostate Problems Comments:____ Psychiatric: None:____ ☐ STD (HIV, Herpes, Chlamydia) ☐ Depression Pregnant Attention Defecit ☐ Nursing Immunologic: None:____ Comments:____ ☐ Anxiety ☐ Lupus ☐ Bipolar ☐ Sjogrens ☐ Schizophrenia ☐ HIV/AIDS Comments:____ Rheumatoid Arthritis Comments: Medication List (Or please attach copy of list) Drug or Vitamin or Eye Drop: Dosage: Taken For: Frequency: Pharmacy you use:

Overall health of patient: