Eyes On Lincoln

Richard L. Powell, O.D. ║ *Stephen P. Gildersleeve, O.D.*
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402.475.9113

NAME: ____ **DATE:** ________________________
FIRST LAST

E-Mail Address: ____

Please circle any of the following that may apply to your eyes:

Distance unclear	Near unclear	Eyes water	Eyes Tire	Redness
Burning	Irritated	Styes	Eye Strain	Eye pain
Grittiness	Itching	Sees spots	Headaches	Double vision
Dizzy spells	Sensitive to light	Haloes around lights	One eye turns in/out	Color Vision

When did symptoms begin? ____

Any unusual secretions from your eyes? Mucus ______________ Watery ______________ Eyelids stuck together when awaken _____________

How long ago was your last eye exam? ______________________________________ **Where at?** _______________________________

Do you use a computer? Yes No **How many hours a day (average)** ____________________

Are you planning to get new glasses today? Yes No Only if Rx changes

Do you wear contacts? Yes No What type?_______________ Avg. wear per day?__________________

Approx. years of wear?________________________ Are you planning to get new contacts today? Yes No

Are you interested in finding out more about laser vision correction Yes No Maybe

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What type of work do you do (occupation) ____**Hobbies** _______________________________

Who is responsible for payment of account? ____

Method of Payment: ____CASH ____CHECK ____CREDIT CARD ____ INSURANCE ____COMBINATION

I acknowledge that I received a copy of the Notice of Privacy Practices. ***Date***______________________________

PATIENT SIGNATURE____

Form Completed by____ **Relationship to patient**___________________________________

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If you have any questions regarding this form,
please call our office at
402.475.9113

Primary Physician: ________________________________**Phone:**______________________**City:**_____________________**DATE:**_____________

Name and phone number of emergency contact person (not at same address) ____

_____ **I take no Medications**

Check all that apply!	Patient	Family	Meds & Dosage
EYES			Are you using eye drops?
Glaucoma	___	___	
Cataract	___	___	
Macular Degeneration	___	___	
Retinal detachment	___	___	
Other (specify)	___	___	
CONSTITUTION			
Fever	___	___	
Weight loss/gain	___	___	
Fatigue	___	___	
Other (specify)	___	___	
CARDIOVASCULAR			
Heart disease	___	___	
High Blood Pressure	___	___	
Stroke	___	___	
High Cholesterol	___	___	
Other (specify)	___	___	
EARS, NOSE, MOUTH, THROAT			
Upper Resp. Infection	___	___	
Sinusitis	___	___	
Mouth/tooth abscess	___	___	
Other (specify)	___	___	
RESPIRATORY			
Asthma	___	___	
Emphysema	___	___	
COPD	___	___	
Other (specify)	___	___	
GASTROINTESTINAL			
GERD/Acid Reflux	___	___	
Crohn's Disease	___	___	
Colitis	___	___	
Digestive problems	___	___	
Other (specify)	___	___	
GENITOURINARY			
Urinary tract infection	___	___	
Kidney disease	___	___	
STD	___	___	
Contraceptives	___	___	
Menopause	___	___	
Other (specify)	___	___	
HEALTH HABITS			
Tobacco Use	___		
Alcohol	___		
Other	___		

	Patient	Family	Meds &Dosage
MUSCULO-SKELETAL			
Osteoporosis	___	___	
Fibromyalgia	___	___	
Arthritis	___	___	
Other (specify)	___	___	
SKIN			
Psoriasis	___	___	
Eczema	___	___	
Acne	___	___	
Other (specify)	___	___	
NEUROLOGICAL			
Headaches, migraines	___	___	
Seizures	___	___	
Epilepsy	___	___	
Multiple Sclerosis	___	___	
Other (specify)	___	___	
PSYCHIATRIC			
Depression	___	___	
Panic disorder	___	___	
Schizophrenia	___	___	
Other (specify)	___	___	
ENDOCRINE			
Diabetes Type I (Juvenile)	___	___	
Diabetes Type II	___	___	
Diabetes is controlled / uncontrolled (circle)			
Thyroid dysfunction	___	___	
Other (specify)	___	___	
BLOOD/LYMPHATIC			
Anemia	___	___	
Large volume blood loss	___	___	
Leukemia	___	___	
Other (specify)	___	___	
ALLERGIC/IMMUNE			
Drug allergy (specify)	___	___	
Environmental allergy	___	___	
Rheumatoid Arthritis	___	___	
Lupus	___	___	
Other (specify)	___	___	

CANCER - Type and Treatment

SURGERIES - Type and Date