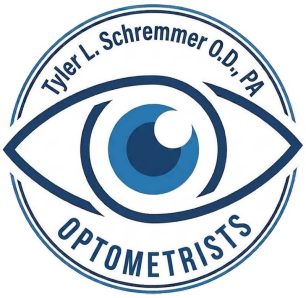
Tyler L. Schremmer, O.D.
Marisa S. Burger, O.D.



801 N. Pine Hoisington KS 67544
(620) 653-2749
M: 8:00 - 7:00
T-F: 8:00-12:00 & 1:00-5:00

New Patient Questionnaire

Name:_____

Date of Birth:_____ **Sex**: ☐ M ☐ F **Last Eye Exam/Doctor**:_____

Address:_____ **State:**_____ **Zip:**_____

Phone number:_____ **Email:**_____

Reason for Visit: ☐ **New glasses** ☐ **New Contacts** ☐ **Medical Other**:_____

Social History: Do you use any of the following:

Alcohol: ☐Yes/☐No **Tobacco**: ☐Yes/☐No **Substance Abuse**: ☐Yes/☐No

Do you drive: ☐Yes/☐No **Occupation**:_____ **Marital Status**:_____

Primary Care Physician:_____

Past Medical, Social, and Eye History

Do you or have you worn glasses? ☐Yes / ☐No (Circle one): Full Time Distance Reading

Have you worn Contact Lenses? ☐Yes / ☐No

Have you ever had an eye injury, infections, or surgery? ☐Yes/☐No

If yes, please describe:_____

Do you have any drug or seasonal allergies? ☐Yes/☐No

If yes, please describe:_____

Do you have headaches, double vision, or sensitivity to light ☐Yes/☐No

If yes, please describe:_____

Do you see flashes of light, floaters, or have vision loss? ☐Yes/☐No

If yes, please describe:_____

Do you currently take any medications? ☐Yes/☐ No

If yes, please List:_____

Family and Personal Health History:

CONDITION	SELF	Family Member: (Circle one)
Arthritis	☐ Yes / ☐No	Father Mother Brother Sister Son Daughter
Cancer	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Diabetes	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Heart Disease	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
High Blood Pressure	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Stroke	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Thyroid Disease	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Cataract	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Glaucoma	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Macular Degeneration	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Lazy Eye / Eye turn	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Blindness	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Retinal Detachment	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Autoimmune	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Excess Tearing / Discharge	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Retinal Disease	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Headaches / Migraines	☐Yes / ☐No	Father Mother Brother Sister Son Daughter
Multiple Sclerosis	☐Yes / ☐No	Father Mother Brother Sister Son Daughter