Established Patient ***Please update*** ***Date:*** _____/_____/_____

Patient Name: Last: _____ **First:** _____ **I prefer to be called:** _____

Reason for Visit: Glasses / Contacts / eye pain / red eye / Other _____

General Health History **Date of last physical exam:** _____/_____/_____

Seasonal allergies	Hypertension	Heart Disease	High Cholesterol	Thyroid Disease
Digestive Problems	Urinary Disorder	Autoimmune Disorder	Skin Disorder	Blood Disorder
Arthritis	Back Pain	Neurologic Disorder	Psychiatric Disorder	Asthma

Diabetes (Date of Diagnosis): _____Type I Type II Doctor that is treating your diabetes: _____

Surgical History (with dates): _____

Eye and Vision History **Date of last eye exam:** _____/_____/_____

Glaucoma	Cataracts	Keratoconus	Lazy Eye	Macular Degeneration
Eye injury	Eye infection	Eye surgery	Floaters	Retinal Detachment
Eye Allergies	Dry Eye	Color Deficiency	Pterygium	Diabetic Retinopathy

Other (Please Specify): _____

Surgical History (with dates): _____

Do you wear glasses? Yes No Date of Prescription: _____Use: Distance Near Computer

Do you wear contacts? Yes No Date of Prescription: _____Type / Brand _____

Medications: _____ _____ _____ _____

_____ _____ _____ _____

Allergies: _____

Smoking Status: Never Smoker Former Smoker Occasional Everyday Years smoked: _____

Family History:

Hypertension:	Relationship: _____	Glaucoma:	Relationship: _____
Diabetes:	Relationship: _____	Macular Degeneration:	Relationship: _____
Heart Disease:	Relationship: _____	Cataracts:	Relationship: _____
Thyroid Disease:	Relationship: _____	Keratoconus:	Relationship: _____

VIKING VISION CENTER

Drs. Michael & Julie Heidish
3384 St. Rt. 752
Ashville, Ohio 43103