



M.D. TORRENCE, O.D., F.A.A.O.
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P R I M A R Y E Y E C A R E
 2311 N. WALDRON
 HUTCHINSON, KANSAS 67502
 620-663-4467

Date _____

Name _____ Street Address _____

City/State _____ Zip Code _____

Home Phone _____ Business Phone _____

Age _____ Date of Birth _____ Business Address _____

Social Security Number _____ Sex _____

Name and Phone of Relative or Friend Outside the Home _____

List All Current Medications _____

Medication Allergies _____

Referred By _____ Family Physician _____

Signature for Examination and Treatment of Person Legally Responsible _____

Responsible Party Social Security Number _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy): _____

Do you *currently* have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, Lupus, Sjogrens, etc.)			

FAMILY HISTORY

M=Mother F=Father S=Sibling GP=Grandparent

DISEASE	YES	NO	Relationship To Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or High blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other (Cataract)			

SOCIAL HISTORY

Current Occupation: _____

Marital Status (married, divorced, single, widowed): _____

Living Arrangements: with family alone nursing home assisted living

Do you drive? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Have you ever tried to wear contact lenses? Yes No

Do you currently wear contact lenses? Yes No

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? Yes No

If YES, how long have you had the current prescription? _____

Do you drink alcohol? Yes No If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke cigarettes? Yes No If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion? Yes No

History Reviewed. No Changes Additions as noted above.

Physician's Signature _____ Date _____