1119 North St. Louis • Batesville, AR 72501
(870) 793-6857

DR. DALE LADD

# WELCOME TO OUR OFFICE

Full Name______________________________

Street______________________________

City________________ State________ Zip____________

Home Phone____________ Work Phone______________

Cell Phone______________________ Texting Ok? ❑

Best # to reach you ______________________

Employer______________________________

Occupation______________________________

Social Security #________________________

Email Address__________________________

Race______________

Preferred Communication:

Postal ❑ Telephone ❑ Text ❑

Family Doctor ______________________

## Current Medications (Rx AND Over the Counter)

Please list ALL current medications:

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

Are you allergic to any Medications? Please list:____________
______________________________

## Family Medical History

| | | Relationship |
|---|---|---|
| Blindness | ❑ Yes ❑ No | ____________ |
| Cataracts | ❑ Yes ❑ No | ____________ |
| Glaucoma | ❑ Yes ❑ No | ____________ |
| Diabetes | ❑ Yes ❑ No | ____________ |
| Heart Disease | ❑ Yes ❑ No | ____________ |
| Macular degeneration | ❑ Yes ❑ No | ____________ |
| Retinal detachment disease | ❑ Yes ❑ No | ____________ |
| High blood pressure | ❑ Yes ❑ No | ____________ |
| Crossed Eyes | ❑ Yes ❑ No | ____________ |
| Arthritis | ❑ Yes ❑ No | ____________ |
| Cancer | ❑ Yes ❑ No | ____________ |
| Thyroid disease | ❑ Yes ❑ No | ____________ |
| Lupus | ❑ Yes ❑ No | ____________ |
| Stroke/TIA's | ❑ Yes ❑ No | ____________ |

* Please specify mother or father's side

Today's Date____________

Previous Eye Doctor______________________

Date of Birth____________ Age_____ Sex M_____ F______

Height______________ Weight______________

Spouse or Parent Name____________________

How will you be paying today?

❑ Cash ❑ Check ❑ Credit Card

## Do you...

| | |
|---|---|
| ...Work at a computer for long periods | ❑ Yes ❑ No |
| ...Have more than one pair of glasses | ❑ Yes ❑ No |
| ...Want information on thinner, lighter lenses? | ❑ Yes ❑ No |
| ...Wear Bifocals? | ❑ Yes ❑ No |
| ...(if yes, are you bothered by head tilting, | ❑ Yes ❑ No |
| restricted areas of vision correction, etc.?) | ❑ Yes ❑ No |
| ...Always like to wear your glasses? | ❑ Yes ❑ No |
| ...Spend time outdoors? (how much) | _____hrs/week |
| ...Have prescription sunglasses | ❑ Yes ❑ No |
| ...Have problems with glare or reflection | ❑ Yes ❑ No |
| particularly when driving at night? | ❑ Yes ❑ No |
| ...Have you ever worn/are currently wearing contacts? | ❑ Yes ❑ No |
| ...Are you planning on getting new contacts today? | ❑ Yes ❑ No |
| ...Are you planning on getting new glasses today? | ❑ Yes ❑ No |
| ...Would you like information of Lasik Correction? | ❑ Yes ❑ No |
| ...Are you interested in having Lasik Correction? | ❑ Yes ❑ No |

## SOCIAL HISTORY

| | |
|---|---|
| Do you use tobacco products? | ❑ Yes ❑ No |
| Do you use alcohol? | ❑ Yes ❑ No |
| Do you use illegal drugs? | ❑ Yes ❑ No |

Have you ever been exposed or infected with:

❑Gonorrhea ❑Hepatitis ❑HIV ❑Syphilis

## SOCIAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Sewing | Y | N | Play Sports | Y | N |
| Swim | Y | N | Gardening | Y | N |
| Woodworking | Y | N | Read | Y | N |
| Dance | Y | N | Crafts/Painting | Y | N |
| Hunt/Fish | Y | N | Work on Computer | Y | N |

Other____________ Hours per day__________

Referred By:______________________________

List all major injuries, surgeries, and/or hospitalizations you have had:________________________________________

List any of the following that you have had: Crossed eye, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:______________________________

Are you pregnant and/or nursing? ☐ Yes ☐ No

## Review of Symptoms

Do you currently or have you ever had any problems in the following areas:

| SYSTEM | NO | YES | ? |
|---|---|---|---|
| **CONSTITUTIONAL** | | | |
| Fever, Weight Loss/Gain | ☐ | ☐ | ☐ |
| **SKIN DISORDERS** | ☐ | ☐ | ☐ |
| **NEUROLOGICAL** | | | |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| **EYES** | | | |
| Loss of Vision | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ |
| Distorted Vision/Halos | ☐ | ☐ | ☐ |
| Loss of Side Vision | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Sandy and Gritty Feeling | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ | ☐ |
| Excess Tearing/Watering | ☐ | ☐ | ☐ |
| Glare/Light Sensitivity | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ |
| Chronic Infection of Eye or Lid | ☐ | ☐ | ☐ |
| Sties or Chalazion | ☐ | ☐ | ☐ |
| Flashes/Floaters in Vision | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ |
| **ENDOCRINE** | | | |
| Thyroid/Other Glands | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Cholesterol | ☐ | ☐ | ☐ |

| | NO | YES | ? |
|---|---|---|---|
| **EARS, NOSE, MOUTH, THROAT** | | | |
| Allergies/Hay Fever | ☐ | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ | ☐ |
| Runny Nose | ☐ | ☐ | ☐ |
| Post-Nasal Drip | ☐ | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | ☐ |
| Dry Throat/Mouth | ☐ | ☐ | ☐ |
| **RESPIRATORY** | | | |
| Asthma | ☐ | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| **VASCULAR / CARDIOVASCULAR** | | | |
| Heart Pain | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |
| **GASTROINTESTINAL** | | | |
| Diarrhea | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| **GENITOURINARY** | | | |
| Genitals/Kidney/Bladder | ☐ | ☐ | ☐ |
| **BONES/JOINTS/MUSCLES** | | | |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ | ☐ |
| Joint Pain | ☐ | ☐ | ☐ |
| **LYMPHATIC/HEMATOLOGIC** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |
| **ALLERGIC/IMMUNOLOGIC** | ☐ | ☐ | ☐ |
| **PSYCHIATRIC** | ☐ | ☐ | ☐ |

**If you have answered YES to any of the above or have a condition not listed, please explain and list medications:**

Date__________ Tech Int_______ Patient History or RDS Changes______________________________ Dr. Int.__________

______________________________ ____________________

Doctor's Signature Date