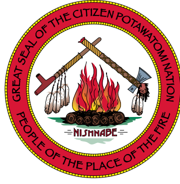

CITIZEN POTAWATOMI NATION OPTOMETRY
2307 S. GORDON COOPER DR., SHAWNEE, OK 74801
PHONE 405-273-5236 FAX 405-878-4835

HISTORY FORM

Place label here

Please check if you (the patient) have any of the following eye conditions currently:

- ☐ Cataracts
- ☐ Dry eyes
- ☐ Blurry Vision
- ☐ Floaters or Spots
- ☐ Light Sensitivity
- ☐ Lazy Eye
- ☐ Redness
- ☐ Burning
- ☐ Retinal Detachment
- ☐ Night Vision Problems
- ☐ Loss of Vision
- ☐ Eye Discharge
- ☐ Double Vision
- ☐ Distorted Vision (Halos)
- ☐ Excess Tearing/Watering
- ☐ Eye Pain/Soreness
- ☐ Flashes of Light
- ☐ Itchy Eyes

Please check if you (the patient) have any of the following health conditions

- ☐ Headaches
- ☐ Hearing Loss
- ☐ Sinus Pressure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Heart Burn
- ☐ Crohn's Disease
- ☐ Bladder/Kidney
- ☐ Muscle Aches
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rashes
- ☐ Psoriasis
- ☐ Migraines
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes
- ☐ Thyroid
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Anemia
- ☐ Leukemia
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Allergies
- ☐ Stroke
- ☐ Autism
- ☐ Pregnancy
- ☐ Cancer
- ☐ Other ____________________

Do you have the following eye conditions?

- ☐ Glaucoma
- ☐ Macular Degeneration if yes, do you see a specialist? ____

CLINIC USE ONLY

Doctor Signature ____

When was your last eye exam and where? ______________________________

How old are your current glasses? ______________________________

List any prescription medications or over the counter medications or eye drops currently taking (That you do not receive here at the CPN Pharmacy).

____

____

____

Please list any medications you are allergic to:

____

____

List any major EYE surgeries you have had:

____

____

Family Ocular History (check all that apply)

- ☐ Glaucoma if yes, who is your family has it? ______________________________
- ☐ Macular Degeneration if yes, who in your family has it? ______________________________

Family Medical History (check all that apply)

- ☐ Diabetes
- ☐ High Blood Pressure

Social History

Do you drink alcohol? ☐ Yes ☐ No

Do you smoke/vape? ☐ Yes ☐ No

Do you use dip/chewing tobacco? ☐ Yes ☐ No