Dr. Brendon J. Johnson, O.D.
2611 Broadway
Pekin, IL 61554
(309) 347-5989

Date_____ Date _____
Date _____ Date _____
Date _____ Date _____
Date _____ Date _____

PATIENT INTAKE FORM

Patient Name: _____ **Date of Birth:** _____

MEDICAL HISTORY

Allergies to Medications: ☐ **No** ☐ **Yes** If yes, list: _____

Pharmacy: _____

Current Medications: _____

_____

_____

_____

Injury, Surgery or Hospitalization: _____

_____

Pregnant or Nursing: ☐ **No** ☐ **Yes**

FAMILY HISTORY

Immediate family only. Check No or Yes and circle what family member is/was affected

Cancer	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
Diabetes	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
High Blood Pressure	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
Thyroid Disease	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
Macular Degeneration	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
Cataracts	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
Glaucoma	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
Retinal Disease	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
		What type? _____					
Autoimmune Disorder	☐ **No** ☐ **Yes**	Father	Mother	Brother	Sister	Son	Daughter
		What type? _____					

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you use tobacco products? ☐ **No** ☐ **Yes** Type/Amount/Duration _____

Do you use illegal drugs? ☐ **No** ☐ **Yes** Type/Amount/Duration _____

Do you drink alcohol? ☐ **No** ☐ **Yes** Type/Amount/Duration _____

Have you been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Chlamydia

Continued on Back ⟹

REVIEW OF SYSTEMS Do you currently have or have had any of the following?

CONSTITUTIONAL

Developmental disabilities ☐ No ☐ Yes
Cancer ☐ No ☐ Yes
Type & year diagnosed _____
In remission? ☐ No ☐ Yes

NEUROLOGICAL

Multiple Sclerosis ☐ No ☐ Yes
Epilepsy/Seizures ☐ No ☐ Yes
Autism ☐ No ☐ Yes
Stroke ☐ No ☐ Yes

PSYCHIATRIC

Depression ☐ No ☐ Yes
Anxiety ☐ No ☐ Yes
ADD/ADHD ☐ No ☐ Yes
Bipolar Disorder ☐ No ☐ Yes

CARDIOVASCULAR/HEMATOLOGIC

Heart Disease ☐ No ☐ Yes
Vascular Disease ☐ No ☐ Yes
High Blood Pressure ☐ No ☐ Yes
High Cholesterol ☐ No ☐ Yes
Anemia ☐ No ☐ Yes

RESPIRATORY/EAR, NOSE & THROAT

Asthma ☐ No ☐ Yes
Emphysema ☐ No ☐ Yes
COPD ☐ No ☐ Yes
Sleep Apnea ☐ No ☐ Yes
Hearing loss ☐ No ☐ Yes

GASTROINTESTINAL/GENITOURINARY

Acid Reflux ☐ No ☐ Yes
Enlarged Prostate ☐ No ☐ Yes

MUSCULOSKELETAL

Fibromyalgia ☐ No ☐ Yes
Arthritis ☐ No ☐ Yes

INTEGUMENTARY/ALLERGIC/IMMUNE

Cold Sores ☐ No ☐ Yes
Shingles ☐ No ☐ Yes
Environmental allergies ☐ No ☐ Yes
Rheumatoid Arthritis ☐ No ☐ Yes

ENDOCRINE

Diabetes ☐ No ☐ Yes
Thyroid Disease ☐ No ☐ Yes

ANY OTHER MEDICAL CONCERNS Please list:

_____
_____

EYES

Blurred Vision ☐ No ☐ Yes
Tired Eyes ☐ No ☐ Yes
Dryness ☐ No ☐ Yes
Itching ☐ No ☐ Yes
Burning ☐ No ☐ Yes
Redness ☐ No ☐ Yes
Tearing/Watering ☐ No ☐ Yes
Glare/Halos ☐ No ☐ Yes
Light Sensitivity ☐ No ☐ Yes
Discharge ☐ No ☐ Yes
Gritty/Foreign Body Sensation ☐ No ☐ Yes
Eye Pain/Soreness ☐ No ☐ Yes
Chronic Infections ☐ No ☐ Yes
Sties or Chalazion ☐ No ☐ Yes
Floaters/Flashes ☐ No ☐ Yes
Loss of Vision ☐ No ☐ Yes
Loss of Side Vision ☐ No ☐ Yes
Double Vision ☐ No ☐ Yes

Have you ever had any of the following?

☐ Crossed Eye ☐ Lazy Eye ☐ Droopy Lid
☐ Glaucoma ☐ Macular Degeneration ☐ Cataract
☐ Eye Injury ☐ Eye Surgery ☐ Eye Infection

Do you wear glasses? ☐ No ☐ Yes
Age of glasses _____
Do you wear contacts? ☐ No ☐ Yes
Brand _____
Age of current pair _____
How often do you change contacts _____

Name of Medical Doctor _____
Last Medical Exam _____
Name of Last Eye Doctor _____
Last Eye Exam _____

For children under 18:

Is the child achieving at expected levels in school?
☐ No ☐ Yes
If no, please explain, including any symptoms while reading: _____
_____
_____