Eye Care Clinic

15 NE 5th Street, Grand Rapids, MN 55744
Dr. Corey Tabbert O.D., Dr. Richard Perrott O.D.

Name:_______________________________ **Date:**_________________

Social History
Do you use tobacco products? *No*:___ *Yes:*___ If yes, type/how long? ____________
Do you drink alcohol? *No*:___ *Yes*:___ If yes, type/how often? ______________
Do you use recreational drugs? *No*:___ *Yes*:___ If yes, how often? ____________

Are you currently pregnant or nursing? *No*:___ *Yes*:___

Review of Systems (please circle one)

Have you been diagnosed with or are you taking medications for the the following:

Cancer (present or past) *If yes, please list what type* ______________________________	No	Yes
Cardiovascular (high blood pressure or cholesterol, pain, arrhythmia)	No	Yes
Constitutional (chronic fever, fatigue, unexpected weight loss or gain)	No	Yes
Endocrine (diabetes, thyroid problems, gout, chrones)	No	Yes
Gastrointestinal (heart burn, abdominal pain, anorexia, hepatitis)	No	Yes
Genitourinary (bladder infections, kidney stones, hernia)	No	Yes
Head (migraines, hearing loss, Meniere's, sinusitis)	No	Yes
Hematologic (anemia, Leukemia, blood clots)	No	Yes
Immunologic (Lyme, HIV, Herpes, AIDS, chicken pox, tuberculosis)	No	Yes
Integumentary (rashes, excessive dryness, rosacea, psoriasis)	No	Yes
Musculoskeletal: (muscle aches, joint pain or swelling, arthritis)	No	Yes
Neurological (seizures, brain damage, brain tumor, epilepsy, vertigo)	No	Yes
Psychiatric (depression, anxiety, ADD, alcoholism, autism, dementia)	No	Yes
Respiratory (asthma, pneumonia, emphysema, COPD)	No	Yes