Eye Care Clinic

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

Please Fill Out Form Completely!

Name:_____ **Date:**_____
Mailing Address:_____
City:_____**State:**_____**Zip:**_____**DOB:**_____
Home Phone:_____ **Cell Phone:**_____
May we leave a message at these phone numbers? YES NO (circle one)
Occupation:_____
Please provide your email address below. We will be sending you a link to be able to securely access your patient record. This email will NOT be used for marketing purposes, but allows both you and your doctor the ability to share information quickly and securely. **Email:**_____

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 following:

Cancer (present or past) 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, Crohn's)	No	Yes
Gastrointestinal (heartburn, 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

Do you currently have eye pain?	No	Yes

If yes, please rate level on a scale of 0 to 10 (10 being the worst)_____