Parker Vision Care 115 W. Riverside Dr. Parker, AZ 85344 (928) 669-2497

Patient Information	Today's Date:	
Last:	First:	Middle:
Date of Birth:	Occupation:	Sex:
Address:		Height:
City, State, Zip:		Weight:

Our preferred method of communication with you will be your cell phone. By signing below, I consent to receive text messages from Parker Vision Care. These messages will **only** be a reminder of an upcoming appointment or a reminder to schedule an appointment. Signature:	Patient Cell #: Parent/Guardian Cell #: Home Phone #:
Email Address:	Social Security #:
Parent/Guardian Name and Date of Birth:	_____ / _____ / _____
Emergency Contact Name:	Relation:
Emergency Contact Phone #:	Primary Care Physician:
Ethnicity:	Language:

Does anyone in your **family** have the following:

- Blindness
- Glaucoma
- Lazy Eye
- Cataracts
- Macular Degeneration
- Diabetes
- High Blood Pressure
- Cancer
- Heart Disease

Have you had any eye surgeries?	Yes No	Type and Date:
Have you had any eye injuries?	Yes No	Type and Date:
Do you wear contact lenses?	Yes No	Type:

Current Medications:

_____

_____

_____

Medical Allergies: _____

Please Proceed to the Next Page

Allergic/Immunologic ☙Drug allergy ☙Environmental allergy ☙Rheumatoid arthritis ☙Lupus ☙Other: _____	**Eyes** ☙Glaucoma ☙Cataracts ☙Macular degeneration ☙Surgery ☙Inflammatory disorders ☙Blurred vision ☙Double vision ☙Other: _____	**Musculoskeletal** ☙Fibromyalgia ☙Muscular dystrophy ☙Osteoarthritis ☙Ankylosing spondylitis ☙Other: _____	**Cardiovascular** ☙Heart disease ☙High blood pressure ☙Stroke ☙Vascular disease ☙Heart attack ☙High cholesterol ☙Other: _____
Gastrointestinal ☙Crohn's ☙Colitis ☙Ulcer ☙Digestive ☙Other: _____	**Neurological** ☙Multiple sclerosis ☙Epilepsy ☙Alzheimer's ☙Parkinson's ☙Cerebrovascular ☙Other: _____	**Constitutional** ☙Developmental disability ☙Weight loss ☙Fever ☙Fatigue ☙Trauma ☙Other: _____	**Genitourinary** ☙STD ☙Viral herpetic ☙Chlamydia ☙Other: _____
Psychiatric ☙Depression ☙Panic disorder ☙Schizophrenia ☙Other: _____	**Ear, Nose, Mouth & Throat** ☙Upper respiratorytract infection ☙Ear ache ☙Runny nose ☙Sore throat ☙Ringing/Tinnitus ☙Other: _____	**Hematologic/Lymphatic** ☙Anemia ☙Large volume blood loss ☙Leukemia ☙Other: _____	**Respiratory** ☙Smoking Status ☙ Current ☙ Former ☙ Never ☙Asthma ☙Bronchitis ☙Emphysema ☙Other: _____
Endocrine ☙Non-insulin dependent diabetes Year diagnosed: _____ ☙Insulin-dependent diabetes ☙Thyroid dysfunction ☙Hormonal dysfunction ☙Other: _____	**Integumentary (Skin)** ☙Eczema ☙Rosacea ☙Psoriasis ☙Other: _____	**Cancer** ☙Type: _____ ☙Year: _____	☙ **I have no medical conditions I am aware of** _____ **Signature** _____ **Date**