Lincoln County Vision Center
Bill Womble, O.D.

1822 Huntsville Hwy Suite D
Fayetteville, TN 37334
(931) 433-1370

Name_____ Date_____/_____/_____
DOB_____/_____/_____ last medical exam date_____ last eye exam date_____
Name of Medical Doctor_____

Personal Medical History

Are you allergic to any medicines? ( ) no ( ) yes List_____
_____
List all medicines you are using (prescription and over-the-counter)_____
_____
List all surgeries or hospitalizations you have had with approximate date_____
_____
List any eye injuries or surgeries you have had_____
_____
Have you ever been told you have: Glaucoma_____ Cataracts_____ Retina Trouble_____
Do you wear glasses? ( ) No ( ) Yes how old are they? _____
Do you wear contacts? ( ) No ( ) Yes what type of lenses?_____
Are you pregnant or nursing? ( ) No ( ) Yes

Family History (please include blood relatives only for conditions below)

Disease/Condition	NO	YES	Relationship to you
Blindness	( )	( )	_____
Glaucoma	( )	( )	_____
Macular Degeneration	( )	( )	_____
Retinal Detachment	( )	( )	_____
Eye drops every day	( )	( )	_____
Arthritis	( )	( )	_____
Cancer	( )	( )	_____
Diabetes (sugar)	( )	( )	_____
High blood pressure	( )	( )	_____
Kidney disease	( )	( )	_____
Thyroid disease	( )	( )	_____
Other_____	( )	( )	_____

PLEASE TURN OVER AND COMPLETE

Social History

List your Marital status ( ) single ( ) married ( ) divorced ( ) widowed
List your occupation ( ) retired ( ) other_____
List your hobbies_____
Do you use tobacco products? ( ) no ( ) yes Do you use alcohol? ( ) no ( ) yes

Review of Organ Systems (do you currently, or have you had problems with any below)

Disease / Condition	NO	YES	EXPLAIN
INTEGUMENT (skin)	( )	( )	_____
NEUROLOGIC			_____
headaches	( )	( )	_____
migraines	( )	( )	_____
seizures	( )	( )	_____
EAR, NOSE, THROAT			_____
allergies	( )	( )	_____
hay fever	( )	( )	_____
sinus trouble	( )	( )	_____
RESPIRATORY			_____
asthma	( )	( )	_____
emphysema	( )	( )	_____
shortness of breath	( )	( )	_____
VASCULAR / HEART			_____
diabetes (sugar)	( )	( )	_____
high blood pressure	( )	( )	_____
heart trouble	( )	( )	_____
GENITO - URINARY			_____
kidney	( )	( )	_____
bladder	( )	( )	_____
BONE / JOINT / MUSCLES			_____
arthritis	( )	( )	_____
back problems	( )	( )	_____
auto immune problems	( )	( )	_____
LYMPHATIC / BLOOD			_____
anemia	( )	( )	_____
bleeding disorders	( )	( )	_____
ENDOCRINE (thyroid)	( )	( )	_____
PSYCHIATRIC	( )	( )	_____
GASTROINTESTINAL	( )	( )	_____
ANY CANCER	( )	( )	_____
ANY OTHER HEALTH PROBLEMS	( )	( )	_____

Doctor's Signature_____ **Date reviewed**_____