5600 Kavanaugh Blvd Ste 8
Little Rock, AR 72207

Kavanaugh Eye Care

Dr. Brian Guice, OD

Tel: 501-614-9900
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Patient Information

Name _____Date _____

Address _____City_____State_____Zip_____

DOB _____ Age _____ Social Security # _____

Phone _____ Email _____

Past, Medical, Family and Social History:

Occupation: _____ Employer:_____

Work on computer? o No o Yes Difficulty seeing to drive? o No o Yes Difficulty reading? o No o Yes

Current Medications: _____

Allergies to medications? o No o Yes If yes, list meds _____

Describe any history of eye-related trauma, surgery, illness, disease, or problems: _____

_____

List diseases or health problems of parents and siblings: _____

_____

Parent or Sibling with any of the following? Glaucoma Diabetes Macular Degeneration Retinal Disease

Are you pregnant and/or nursing? o No o Yes Check if ever exposed: □ Hepatitis □ HIV □ Syphilis □ Tuberculosis

Do you use tobacco products? □ No □Yes Do you drink alcohol? □ No □Yes

Review of Systems:

Please check current and chronic symptoms and conditions:

Constitutional	Yes	No
Fever	o	o
Weight Gain/Loss	o	o
Eyes		
Blurred Vision	o	o
Burning or Irritation	o	o
Cloudy or Hazy Vision	o	o
Distorted Vison	o	o
Double Vison	o	o
Flashes / Floaters in Vision	o	o
Foreign Body Sensation	o	o
Glare / Light Sensitivity	o	o
Itching	o	o
Mucous Discharge	o	o
Pain or Soreness	o	o
Pressure		
Redness	o	o
Sandy or Gritty Feeling	o	o
Styes or lid bumps	o	o
Tearing / Watering	o	o
Bone / Joint / Muscle		
Arthritis	o	o
Back / Jaw / Bone Pain	o	o
Joint / Muscle Pain	o	o
Endocrine		
Hyperthyroid	o	o
Hypothyroid	o	o
Ear, Nose, and Throat		
Allergies	o	o
Dry Mouth / Throat	o	o
Hay Fever / Sneezing	o	o
Runny Nose	o	o
Sinus Congestion	o	o

Cancer	Yes	No
Skin / Melanoma	o	o
Lymphatic / Hematologic		
AIDS	o	o
Anemia	o	o
Bleeding Disorders	o	o
Hepatitis	o	o
Herpes	o	o
HIV Positive	o	o
Liver Disease	o	o
Neurologic		
Epilepsy	o	o
Headaches	o	o
Migraines	o	o
Multiple Sclerosis	o	o
Seizures	o	o
Reproductive		
Nursing Mother	o	o
Pregnant	o	o
Respiratory		
Asthma	o	o
Chronic Bronchitis	o	o
Emphysema	o	o
Pneumonia	o	o
Tuberculosis	o	o
Vascular		
Cholesterol	o	o
Diabetes Type 1	o	o
Diabetes Type 2	o	o
Heart Disease	o	o
High Blood Pressure	o	o
Low Blood Pressure	o	o
Stroke	o	o

Patient Signature: _____ Date: _____