Vision Source Signature Eye Care

Dr. David C. Brewer, Optometric Physician

1207 Cornwell Dr.
Yukon, OK 73099
405-354-3384
www.drdavidbrewer.com

Name:______________________ Today's Date:______________________

Address:______________________ Cell Phone:______________________

City:__________ State:__________ Zip:__________ Home Phone:______________________

Guardian (If Applicable):______________________ Work Phone:______________________

Email:______________________ Occupation:______________________

Gender:__________ Preferred Method of contact: ☐ Cell ☐ Home ☐ Work ☐ Email ☐ Text

Race/Ethnicity:______________________ Preferred Language:______________________

Birth Date:__________ Social Security:__________ Date of Last Eye Exam:__________

Medical Dr.:______________________ Date of Last Medical Exam:__________

Spouse:______________________ Spouse Employer:______________________

Emergency Contact and Phone Number:______________________

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Medical History

Do you have any allergies to medications? No: ☐ Yes: ☐ If Yes, explain:______________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter vitamins and home remedies):

____

____

____

____

Are you pregnant or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes how old is your present pair of lenses?__________

Do you wear contact lenses? ☐ No ☐ Yes If yes how old is your present pair of lenses?__________

Type of contact lenses: ☐ Rigid ☐ Soft Are they Comfortable? ☐ Yes ☐ No

Social History: *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History information directly with my doctor

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long:______________________

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long:______________________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long:______________________

Please Turn This Form Over & Complete Side Two