212 S. MAIN ST., HOBART, OKLA 73651
(580) 726-3301 fax (580) 726-3302
DR. TYSON ALLARD O.D.

Today's Date _____

Last Name _____ First Name _____ MI____
Address _____ City _____ State _____ Zip_____
Home #( )_____ Cell # ( )_____ Work #( )_____
Height_____ Weight_____ Male_____ Female_____
SSN_____ DOB_____/_____/_____
Emergency Contact Name_____ # ( )_____
Parent/Guardian Name_____ #( )_____
Occupation_____ Employer_____

PERSONAL EYE INFORMATION

Eye surgeries/injuries_____ Date_____
Head Injuries _____ Date_____
Have you or do you have any of the following:
Retinal Detachment Yes / No Macular Degeneration Yes / No Glaucoma Yes / No
Blurred Vision Yes / No Dry Eyes Yes/ No Cataracts Yes / No
Other_____

FAMILY HISTORY

Diabetes Yes/No Relation _____ Macular Degeneration Yes/No Relation_____
Glaucoma Yes/No Relation_____ Retinal Detachment Yes/No Relation_____
Cataracts Yes/No Relation _____ High Blood Pressure Yes/No Relation_____
Asthma Yes/No Relation _____ Tuberculosis Yes/No Relation_____
Thyroid Yes/No Relation _____ Blindness Yes/No Relation_____

MEDICAL HISTORY

Do you have problems/symptoms related to any of the following: (please circle yes or no)
Diabetes Yes/No What type? _____
Date of diagnosis _____

Headaches	Yes/No	Blood	Yes/No	High Blood Pressure	Yes/No
Ears/Nose/Throat	Yes/No	Heart	Yes/No	Gastrointestinal	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Muscles/Skeletal	Yes/No
Nervous/nerves	Yes/No	Urinary	Yes/No	Endocrine (glands)	Yes/No
Lymph	Yes/No	Immune	Yes/No	Fainting or Dizzy Spell	Yes/No

Other _____
Allergies to Medication(s) Yes / No If so, what? _____
Reaction? _____
Current Medications: _____
_____
Surgery(s) and the dates:_____
_____
Family Physician _____ Phone # ( )_____
Address_____
Date of last eye exam _____ Dilated Yes/No
Date of last tetanus shot _____ Questions? _____