300 W. Broadway St.
Eagle Grove, IA 50533
Phone: 515-448-3813

Broadway Vision Source
Dr. Brandon Hauck
Fax: 515-448-3885

Last Name: ____________________________ First Name: ____________________________ MI: _____ Address: ____________________ City: ____________ State: ____ Zip Code: _________

Home Phone: ________________________ Cell Phone: _______________________ Email address: _____________________________________ Height: _________ Weight: ________

DOB: __________ SSN: ________________________ ☐ Male ☐ Female Preferred method of contact for us to leave message: Home Phone Cell Phone

(please circle) Employed Self-Employed Retired Student Other If Employed- Name of Employer: _____________________ Occupation: ______________________

(please circle) Single Married Divorced Widowed Other If Married- Name of Spouse: _________________ DOB: __________ SSN: ________________

********IF PATIENT IS A CHILD********

Mother's Name: __________________________ Phone: _______________ Father's Name: __________________________ Phone: _______________

Primary Physician: ____________________ Practice Name: ________________________ City: ________________ Preferred Pharmacy: ____________________ City: ________________

Is the patient allergic to any medications: Y / N if yes list: _____________________________

Does the patient wear contact lenses: YES NO Brand: _____________________________

List any medication the patient is taking **including over the counter**

____
____
____
____
____

CIRCLE ALL THAT APPLY

General
Fever
Weight Loss
Weight Gain
Fatigue

Ear/Nose/Throat
Allergies
Sinus
Cough/Chronic Cough

Cardiovascular
High BP
Heart Surgery
Vascular Disease

Respiratory
Asthma Bronchitis
Emphysema
COPD

Kidney/Bladder
Painful Urination
Frequent Urination
Impotence
Yellow Jaundice

Muscles/Bones/Joints
Joint Pain
Stiffness
Swelling
Cramps
Arthritis

Skin
Pimples/Warts
Growths
Rash

Neurological
Numbness/Paralysis
Headache
Migraines
Seizures

Psychiatric
Anxiety
Depression
Insomnia

Endocrine
Diabetes
Hypo-thyroid
Hyper-thyroid

Blood/Lymph
Bleeding
High Cholesterol
Anemia

Allergic/Immunologic
Sneezing
Swelling
Redness
Itching
Hives
Lupus

Gastrointestinal
Diarrhea
Constipation
Ulcer
Acid Reflux

YOUR PERSONAL HEALTH HISTORY- Please Circle ALL that apply

Blurry Vision	Eyedrops	Eye Strain/Fatigue	Itching
Burning	Eyes feel sandy/gritty	Flashes	Lazy Eye
Cataracts	Eye Pain	Floaters	Light Sensitive
Contact Lens	Eye Infection	Glare/Halos	Macular Deg
Dry Eyes	Eye Injury	Glasses	Redness
Discharge	Eyelid Droop	Glaucoma	Retinal Detach
Double Vision	Eye Surgery	Headaches	Watery

Any Other Health Conditions: ____
____

Tobacco Use: YES / NO
Chewing/Cigarettes/Cigar/Pipe

Alcohol Use: YES / NO
Beer/Wine/Liquor/All

Recreational Drug Use:
YES / NO

Patient/Guardian Signature: ______________________________ Date: ___________