Kunkel-Snyder
OPTOMETRIC

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Watertown, SD 57201
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Beth A. Kunkel, O.D.
Matt C. Kunkel, O.D.

**TODAY'S DATE** ____________________

**LAST NAME** _________________________________ **FIRST NAME** _________________________ **MI** __________

**ADDRESS** ____________________________ **CITY** _______________________ **STATE** _______ **ZIP** ___________

**BIRTHDATE** ________________ **AGE** _______ **SEX ( ) M OR ( ) F SOC. SEC #** _________________________

**PHONE: HOME** __________________ **CELL** ____________________ **Email**_________________________________

**EMPLOYER** ___________________________________________ **WORK PHONE #** ___________________________

**SPOUSE'S NAME** ________________________________ **BIRTHDATE** _______________ **WORK #** ____________

## RESPONSIBLE PARTY INFORMATION (If other than patient)

**FATHER'S NAME** ______________________________________________________ **BIRTHDATE** ______________

**ADDRESS** ______________________________________ **CITY** __________________ **STATE** _____ **ZIP** ________

**SOCIAL SECURITY #** ____________________________________ **PHONE** __________________________________

**EMPLOYER** ____________________________________________ **WORK #** ________________________________

**MOTHER'S NAME** ______________________________________ **BIRTH DATE** _____________________________

**ADDRESS** ______________________________________ **CITY** __________________ **STATE** ______ **ZIP** _______

**SOCIAL SECURITY #** ___________________________________ **PHONE** __________________________________

**EMPLOYER** _____________________________________________ **WORK #** ______________________________

## Emergency Contact

**LAST NAME** _____________________________________ **FIRST NAME** ____________________________________

**ADDRESS** _________________________________ **CITY** _____________________ **STATE** ______ **ZIP** _________

**PHONE: HOME** ____________________________ **RELATIONSHIP** _______________________________________

**PLEASE TURN OVER**

# HEALTH HISTORY

**PATIENT NAME: __________________________________________________**

**DATE OF BIRTH: __________________________________________________**

**PLEASE FILL OUT THE FOLLOWING INFORMATION BY PLACING AN (X) IN THE BOX IF THIS INFORMATION PERTAINS TO YOU:**

**CARDIOVASCULAR**

( ) Angina ( ) Irregular Heart Beat ( ) Bypass Graft ( )Chest Pain ( ) Heart Murmur
( ) Congestive Heart Failure ( ) Coronary Artery Disease ( ) Heart Palpitation
( ) High Blood Pressure ( ) High Cholesterol ( ) Mitral Valve Prolapse ( ) Blood Clots
( ) Pace Maker ( ) Valve Replacement ( ) Rheumatic Fever ( ) ____________________

**RESPIRATORY**

( ) Asthma ( ) Bronchitis ( ) Shortness of Breath ( ) Emphysema ( ) Pneumonia
( ) COPD ( ) Tuberculosis ( ) Obstructive Sleep Apnea ( ) Home Oxygen ( ) Cough
( ) ____________________

**GASTROINTESTINAL**

( ) Abdominal Pain ( ) Bowel Cancer ( )Change in Appetite ( ) Constipation ( ) Diarrhea
( ) Difficulty swallowing ( ) Ulcers ( ) Diverticulitis ( ) Gallbladder Disease ( ) Nausea
( ) Reflux/Heartburn ( ) Hiatal Hernia ( ) Hepatitis ( ) Liver Disease ( ) Jaundice
( ) Pancreatitis ( ) ______________________

**GENITOURINARY/ENDOCRINE**

( ) Bladder Infections ( ) Bladder Repair ( ) Bladder Spasms ( ) Frequent Urination
( ) Recurrent Urinary Infections ( ) Changes in Color of Urine ( ) Incontinence
( ) Kidney Failure ( ) Kidney Stones ( ) Kidney Transplant ( ) Diabetes ( ) Dialysis
( ) Thyroid Disorder ( ) ______________________

**MUSCULOSKELTAL**

( ) Back Pain ( ) Neck Pain ( ) Cerebral Palsy ( ) Gout ( ) Rheumatoid Arthritis
( ) Multiple Sclerosis ( ) Muscular Dystrophy ( ) Parkinson's ( ) ___________________

**NEUROLOGICAL/PSYCHIATRIC**

( ) Bells Palsy ( ) Cranial Nerve Palsy ( ) Paralysis ( ) Epilepsy ( ) Migraines ( ) Seizures
( ) Dizziness ( ) Stroke ( ) TIA ( ) Depression ( ) Dementia ( ) Panic Episodes
( ) Anxiety ( ) ______________________

**ALLERGIC/IMMUNOLOGIC**

( ) HIV ( ) Immune Disorder ( ) Lupus ( ) Seasonal Allergies ( ) Allergy Shots

**OTHER**

( ) Basal Cell Carcinoma ( ) Bruising ( ) Dermatitis ( ) Eczema ( ) Excessive Sweating
( ) Itching ( ) Psoriasis ( ) Skin Cancer ( ) Skin Rash ( ) Cancer ___________________
( ) Hearing Aides ( ) Dentures ( ) _____________________

**PREVIOUS SURGERIES:**

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____________________________________
____________________________________
____________________________________
____________________________________

**ALLERGIES:**

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**PLEASE LIST CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS**

| MEDICATION NAME | DOSE | FREQUENCY |
|---|---|---|
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**Primary Care Physician:** ____________________________________________________________

**Preferred Pharmacy:**________________________________________________________________

Kunkel-Snyder Optometric has my permission to file claims and receive payments from my insurance benefit for today's services and goods. I understand that I am responsible for any amount that is not covered by my insurance.

**Patient Signature:**_____________________________________**Date:**_________________