**MUSKOGEE BRIDGES OUT OF POVERTY & CENTRAL BAPTIST CHURCH HEALTH CARE MINISTRY**

**VISION PATIENT APPLICATION FORM**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long at this address? \_\_\_\_\_\_\_\_\_\_ Church Affiliation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male\_\_\_\_ Female \_\_\_\_ Marital Status: Married\_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Widow \_\_\_\_\_

When was the last time you had an eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? Yes \_\_ No \_\_ Have you had cataract surgery? Yes \_\_ No \_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever worn glasses? Yes \_\_ No \_\_ when did you wear them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are not wearing glasses now, the reason is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an injury to one or both eyes? Yes \_\_ No \_\_ Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, describe the reason you would like an eye exam and/or glasses. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any of the following: Please list medications you are currently taking:**

(Please circle **Y** for yes or **N** for no) Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Aspirin

Y N Ibuprofen Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Sulfa Drugs

Y N Penicillin Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Codeine

Y N Latex, Metals Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Anesthetics

Y N Other medications Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you had any of the following? (Please circle **Y** for yes or **N** for no)

Y N Heart Disease Y N Liver Disease Y N Heart Murmur

Y N Congenital Heart Lesions Y N Jaundice Y N Hepatitiis

Y N Diabetes Y N Rheumatic Fever Y N Excessive Urination or thirst

Y N Abnormal Blood Pressure Y N Herpes Y N Mononucleosis (Mono)

Y N Bleeding Disorder Y N Arthritis Y N Tuberculosis or Lung Disease

Y N Asthma Y N Hay Fever Y N Kidney Disease

Y N Sinus Trouble Y N Hearing Loss Y N Fainting Spells/ Dizziness

Y N Cancer/ Chemotherapy Y N Radiation Treatment Y N Tumor

Y N Ulcers Y N Drug Use/ Addiction Y N Emotional or Nervous Disorder

Y N I smoke or use tobacco If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
I am currently **actively participating** in Doorways of Hope or a local Celebrate Recovery Chapter. Yes \_\_\_\_\_ No \_\_\_\_\_   
  
I am a **Bridges Out of Poverty Getting Ahead Investigator**: Current \_\_\_\_\_\_ or Graduation Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Application reviewed by the Central Baptist Church Faith Community Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_