PATIENT INFORMATION

PATIENT'S NAME____
(PLEASE PRINT) Last First Middle Initial

Home Address______________________ **City, State & Zip**______________________

Telephone **Home**______________ **Work**______________ **Cell** ______________

Marital Status…married…single…divorced…widowed **Email Address**______________________

Where do you prefer we call you?______________ **Occupation**__________ **Employer**______________

Date of Birth_____-_____-_____ **Age**_______ **Male**_______ **Female**_______

Patient's Social Security Number_____-_____-_____ **If Patient is a Child, Parent's Name**______________

Referred By Name: ______________________ **or Location YellowPages Insurance Website**

Name of immediate family members seen in our office?______________________________

PERSON RESPONSIBLE FOR BILL

Name____
Last **First** **Middle Initial**

Social Security Number_______-_____-______ **Date of Birth**_____-____-____ **Spouse'sName**______________

Address______________________ **City, State &Zip**______________________

Telephone **Home**______________ **Work**______________ **Cell**______________

Occupation______________________ **Employer**______________________

FAMILY INFORMATION

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU ______________________________

ADDRESS______________________ **City, State & Zip**______________________

TELEPHONE______________________ **RELATIONSHIP**______________________

INSURANCE INFORMATION

Vision Insurance Company______________ **Member ID Number**______________ **Group Number**________

Member Name______________________ **Date of Birth**________ **Member Employer**______________

Major Medical Insurance Company__________ **Member ID Number**______________ **Group Number**________

Member Name______________________ **Date of Birth**________ **Member Employer**______________

DO YOU….(CHECK BOX IF YOUR ANSWER IS YES)

☐..work at a computer? **☐..think you might benefit from thinner, lighter lenses?** **☐..have prescription sunwear?**

☐..want information on Laser Vision Correction surgery? **☐..have more than 1 pair of current Rx eyewear?**

☐..have family members in need of eyecare? **☐..have interest in non-surgical approach to vision correction?**

" I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF D. TODD WYLIE, O.D.'S NOTICE OF PRIVACY PRACTICES."

NAME____ **Date**__________

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ________________________
Other Physician________________________________
Date of Last Physical Check-up____________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)________________________________
____
____
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? __________________________
____

Have you had any surgeries? ❑ Yes ❑ No

Do you use			Amount
cigarettes/tobacco,	❑ Yes	❑ No	______________
alcohol	❑ Yes	❑ No	______________
other substances?	❑ Yes	❑ No	______________

Have you ever been diagnosed or treated for the following health problems?

	Yes	No	Please explain
Allergies	❑	❑	______________
Arthritis	❑	❑	______________
Blood/Lymph	❑	❑	______________
Bronchitis	❑	❑	______________
Cancer	❑	❑	______________
Cholesterol	❑	❑	______________
Diabetes	❑	❑	______________
Digestive	❑	❑	______________
Ears/Nose/Throat	❑	❑	______________
Endocrine	❑	❑	______________
Eczema/Rashes	❑	❑	______________
Fatigue	❑	❑	______________
Fevers	❑	❑	______________
Genitourinary	❑	❑	______________
High Blood Pressure	❑	❑	______________
Integumentary (Skin)	❑	❑	______________
Kidney	❑	❑	______________
Muscle/Bone	❑	❑	______________
Neurological	❑	❑	______________
Psychological	❑	❑	______________
Respiratory	❑	❑	______________
Sinus	❑	❑	______________
Throat Infections	❑	❑	______________
Thyroid	❑	❑	______________
Unusual weight losses/gains	❑	❑	______________

Patient Signature________________________________

Date Reviewed		Changes
______________	❑No Changes	______________
______________	❑No Changes	______________
______________	❑No Changes	______________
______________	❑No Changes	______________

Patient Eye History

Date of Last Eye Exam __________________________
By Whom?_____________________________________

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infection
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders___________________________
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night
- ❑ Dry Eyes

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
(Please check boxes)

		Relationship (Mother's or Father's side)
Blindness	❑	______________________
Cataracts	❑	______________________
Corneal Problems	❑	______________________
Diabetes	❑	______________________
Glaucoma	❑	______________________
Heart Disease	❑	______________________
Lazy Eye	❑	______________________
Macular Degeneration	❑	______________________
Retinal Problems	❑	______________________
Thyroid	❑	______________________

Visual Performance Questions

Do you:

- ❑ enjoy reading?
- ❑ skip words or lines when reading?
- ❑ comprehend and retain what you read?
- ❑ get carsick, worse while in the backseat?
- ❑ see words move or wiggle on the page?
- ❑ find reading speed slows with time?
- ❑ get overwhelmed/anxious easily?
- ❑ do any family members experience any of above?