

**Appointment Date** \_\_\_\_\_

**Patient Information**

Last \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parent's Work) \_\_\_\_\_

Sex M F

**Person Responsible for Bill:**

Last \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

Email Address: \_\_\_\_\_

What is the major purpose for this visit?  
\_\_\_\_\_

**VERY IMPORTANT! NEW PATIENTS ONLY:**

Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

Another Dr. Name \_\_\_\_\_

Insurance List Name \_\_\_\_\_

Saw Sign/Building

Yellow Pages: Which directory? \_\_\_\_\_

Web Page: Which Web Site? \_\_\_\_\_

Other \_\_\_\_\_

**Insurance Information**

**Vision Insurance** \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Secondary Vision? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Medical Insurance** \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Do you participate in a flex spending account?

Yes  No

How will you settle your account today?

Cash  Check  Credit Card

**Lifestyle Questions**

**Do you.....(check box if your answer is yes)**

..work at a computer? If yes, please complete computer questionnaire.

..think you might benefit from thinner, lighter lenses?

..have interest in a "test drive" of the latest contact lens designs

..spend time outdoors? How much? \_\_\_Hrs/week

..have prescription sunwear?

..prefer not to wear your glasses at times?

..want information on Laser Vision Correction surgery?

..have interest in a non-surgical approach to vision correction?

..have more than 1 pair of current Rx eyewear?

..have children?

..have family members in need of eyecare?

Have you ever tried contact lenses?  Yes  No

Do you currently wear contact lenses?  Yes  No

What kind? \_\_\_\_\_

Solutions used \_\_\_\_\_

Would you prefer clear contact lenses or colored contact Lenses?  Clear  Colored

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

Signature \_\_\_\_\_ 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 _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b>	
(List name of medications including eye drops, vitamins, & birth control pills) _____	
_____	
_____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	
_____	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Do you use</b> <span style="float: right;">Amount</span>	
cigarettes/tobacco, <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<b>Have you ever been diagnosed or treated for the following health problems?</b>	
	<b>Yes No Please explain</b>
Allergies	<input type="checkbox"/> <input type="checkbox"/> _____
Arthritis	<input type="checkbox"/> <input type="checkbox"/> _____
Blood/Lymph	<input type="checkbox"/> <input type="checkbox"/> _____
Bronchitis	<input type="checkbox"/> <input type="checkbox"/> _____
Cancer	<input type="checkbox"/> <input type="checkbox"/> _____
Cholesterol	<input type="checkbox"/> <input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> <input type="checkbox"/> _____
Digestive	<input type="checkbox"/> <input type="checkbox"/> _____
Ears/Nose/Throat	<input type="checkbox"/> <input type="checkbox"/> _____
Endocrine	<input type="checkbox"/> <input type="checkbox"/> _____
Eczema/Rashes	<input type="checkbox"/> <input type="checkbox"/> _____
Fatigue	<input type="checkbox"/> <input type="checkbox"/> _____
Fevers	<input type="checkbox"/> <input type="checkbox"/> _____
Genitourinary	<input type="checkbox"/> <input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> _____
Integumentary (Skin)	<input type="checkbox"/> <input type="checkbox"/> _____
Kidney	<input type="checkbox"/> <input type="checkbox"/> _____
Muscle/Bone	<input type="checkbox"/> <input type="checkbox"/> _____
Neurological	<input type="checkbox"/> <input type="checkbox"/> _____
Psychological	<input type="checkbox"/> <input type="checkbox"/> _____
Respiratory	<input type="checkbox"/> <input type="checkbox"/> _____
Sinus	<input type="checkbox"/> <input type="checkbox"/> _____
Throat Infections	<input type="checkbox"/> <input type="checkbox"/> _____
Thyroid	<input type="checkbox"/> <input type="checkbox"/> _____
Unusual weight losses/gains	<input type="checkbox"/> <input type="checkbox"/> _____
Patient Signature _____	
Date Reviewed	Changes
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> 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? <input type="checkbox"/> Burning	
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Corneal Abrasions
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Crossed eye/Eye turn	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Floaters/Spots
<input type="checkbox"/> Flash of light	<input type="checkbox"/> Grittiness
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Headaches	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Itchiness	<input type="checkbox"/> Occasional dryness
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Tearing	<input type="checkbox"/> Dry Eyes
<input type="checkbox"/> Uncomfortable glasses	_____
<input type="checkbox"/> Other eye disorders	_____
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: (Please check boxes)	
<b>Relationship</b>	
(Mother's or Father's side)	
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Thyroid	<input type="checkbox"/> _____
Visual Performance Questions	
Do you:	
<input type="checkbox"/> enjoy reading?	
<input type="checkbox"/> skip words or lines when reading?	
<input type="checkbox"/> comprehend and retain what you read?	
<input type="checkbox"/> get carsick, worse while in the backseat?	
<input type="checkbox"/> see words move or wiggle on the page?	
<input type="checkbox"/> find reading speed slows with time?	
<input type="checkbox"/> get overwhelmed/anxious easily?	
<input type="checkbox"/> do any family members experience any of above?	