Wylie Eye Center

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PATIENT'S NAME _____ **DATE** _____

GENDER (circle one) ***M F*** **RACE (circle one)** ***WHITE AFRICAN-AMERICAN HISPANIC ASIAN AMERICAN INDIAN OTHER***

MARITAL STATUS (circle one) ***MARRIED SINGLE DIVORCED WIDOWED LEGALLY SEPARATED***

ETHNICITY (circle one) ***HISPANIC OR LATINO NATIVE HAWAIIAN/ OTHER PACIFIC ISLAND NOT HISPANIC/LATINO***

PREFERRED LANGUAGE _____ **APPROXIMATE HEIGHT** _____ **APPROXIMATE WEIGHT** _____**lbs**

PATIENT'S BIRTHDATE _____ **PARENT OR GUARDIAN (if a minor)** _____

MAILING ADDRESS _____ **CITY**_____ **STATE**_____

ZIP _____ **HOME PHONE#** _____ **CELL PHONE #** _____

PREFERRED METHOD OF COMMUNICATION (circle one) ***PHONE EMAIL LETTER*** **PREFERRED DAYTIME PHONE#** ***HOME CELL PHONE OTHER***

EMAIL _____ **SS# (if using insurance)** _____

OCCUPATION _____ **EMPLOYER OR SCHOOL** _____ **GRADE** _____

INSURED MEMBER'S NAME & DATE OF BIRTH _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

MY VISIT TODAY IS FOR (circle one): ***GLASSES CONTACT LENSES LASER VISION CORRECTION OFFICE VISIT***

OTHER (please explain) _____ **DATE OF LAST EYE EXAM** _____ **DOCTOR**_____

MEDICAL HISTORY: **ARE YOU PREGNANT AND/OR NURSING AT THIS TIME?** ***YES NO*** **TOBACCO USE ?** ***PREVIOUS NEVER CURRENT***

LIST ALL MEDICAL CONDITIONS: _____

_____

LIST ALL MEDICATIONS (including eye drops and over-the-counter) YOU ARE CURRENTLY TAKING: _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ***YES NO*** **LIST** _____

EYE HISTORY: **EYE INJURIES (foreign objects, black eye, etc.)** ***YES NO***

EYE DISEASE ***YES NO*** **EYE SURGERY (cataract, laser vision correction, etc.)** ***YES NO***

IF YES TO ANY ABOVE, PLEASE TELL WHAT AND WHEN: _____

_____

DO YOU WEAR CONTACTS? YES NO IF SO, TYPE _____

*** ADDITIONAL INFORMATION ON SECOND PAGE**

EYES (Ocular symptoms)

Eye pain or soreness	YES	NO
Fatigue / tired eyes	YES	NO
Dry / Gritty feeling	YES	NO
Redness	YES	NO
Burning	YES	NO
Itching	YES	NO
Excess watering	YES	NO
Mucous discharge	YES	NO
Chronic infections	YES	NO
Squinting	YES	NO
Glare / light sensitivity	YES	NO
Halos around lights	YES	NO
Double vision	YES	NO
Loss of vision	YES	NO
Blurred vision	YES	NO
Flashes	YES	NO
Floaters	YES	NO

CONSTITUTIONAL

Fever	YES	NO
Weight loss or gain	YES	NO

SKIN

Rosacea (adult acne)	YES	NO
Metal allergies	YES	NO

EAR, NOSE, THROAT, MOUTH

Allergies / Hay fever	YES	NO
Sinus infections	YES	NO
Hearing loss	YES	NO

RESPIRATORY

Asthma	YES	NO
Chronic bronchitis	YES	NO
Emphysema	YES	NO

VASCULAR / CARDIOVASCULAR

Heart disease	YES	NO
High blood pressure	YES	NO
High cholesterol	YES	NO
Stroke	YES	NO

GASTROINTESTINAL

Acid reflux	YES	NO
Intestinal problems	YES	NO
Liver / spleen	YES	NO

ENDOCRINE

Thyroid / other glands	YES	NO
Diabetes	YES	NO

GENITOURINARY

Genitals/kidney/bladder	YES	NO

LYMPHATIC/HEMATOLOGIC

Anemia	YES	NO
Bleeding	YES	NO

BONES/JOINTS/MUSCLES

Rheumatoid arthritis	YES	NO
Muscle/joint pain	YES	NO

NEUROLOGICAL

Headaches	YES	NO
Seizures	YES	NO
Alzheimer's	YES	NO
Parkinson's	YES	NO

PSYCHIATRIC

Depression	YES	NO
Anxiety	YES	NO
Other	YES	NO

IMMUNE SYSTEM YES NO

FAMILY HISTORY

Glaucoma	YES	NO
Macular Degeneration	YES	NO
Cataracts	YES	NO
Retinal Detachment	YES	NO
Diabetes	YES	NO
Heart Disease	YES	NO

NOTES_____

_____

_____

_____

Patient Name _____

Date_____