Wyandotte Optical

Patient Information Form

Today's Date:_____

DEMOGRAPHIC INFORMATION

Last Name:
First Name: M.I.:
Title: Suffix:
Address 1:
Address 2:
City:
State: Zip Code:
Primary Phone:
Daytime Phone:
Cell Phone:
Email:
Last eye exam:

Gender:
Date of Birth:
Last 4 of Social Security Number:
Marital Status:
Employment status:
Employer:
Occupation:
Preferred Language:
Race:
Ethnicity:
Referral:
Communication Pref:

INSURANCE INFORMATION

Insurance 1

Insurance Name:
Insured ID:
Policy Group:
Relationship to Insured:

Insured Party Information

Last Name:
First Name:
Title: Suffix:
Date of Birth:
Social Security Number:
Address 1:
Address 2:
City:
State: Zip Code:
Primary Phone:
Daytime Phone:
Gender:
Employer:
Additional Info:

Insurance 2

Insurance Name:
Insured ID:
Policy Group:
Relationship to Insured:

Insured Party Information

Last Name:
First Name:
Title: Suffix:
Date of Birth:
Social Security Number:
Address 1:
Address 2:
City:
State: Zip Code:
Primary Phone:
Daytime Phone:
Gender:
Employer:
Additional Info:

REASON FOR VISIT AND PRIMARY CARE PHYSICIAN

Reason for Visit:
Additional Information
Primary Care Physician:
Date of last visit:
Are you currently under the care of a Physician?
If yes, please list the reason:
Date your blood pressure was checked:

HISTORY OF PRESENT ILLNESS (HPI)

Are you currently experiencing any of the following?

[ ] Blurred Distance Vision
[ ] Blurred Near Vision
[ ] Burning Eyes
[ ] Double Vision
[ ] Dry Eyes
[ ] Eye Strain
[ ] Flashes of Light
[ ] Gritty Feeling Eyes
[ ] Headaches
[ ] Itchy Eyes
[ ] Loss of Vision
[ ] Night Vision Problems
[ ] Object Floating in Vision
[ ] Pain in Eyes
[ ] Red Eyes
[ ] Sensitivity to Light
[ ] Watery Eyes

PATIENT HISTORY

Medical History

Are you currently experiencing or have you ever experienced any problems in the following areas?

[ ] AIDS/HIV
[ ] Allergy
[ ] Arthritis
[ ] Blood
[ ] Cancer
[ ] Cardiovascular
[ ] Constitutional
[ ] Diabetes 1 or 2
[ ] Ears, Nose, Throat, Mouth
[ ] Endocrine
[ ] Gastrointestinal
[ ] Genitourinary
[ ] Heart Disease
[ ] Hematologic/Lymphatic
[ ] High Blood Pressure
[ ] Immunologic
[ ] Integumentary (Skin)
[ ] Kidney Disease
[ ] Musculoskeletal
[ ] Neurological
[ ] Psychiatric
[ ] Respiratory
[ ] Thyroid Disease

Heart Failure: Yes / No

Are you pregnant?

Ocular History

Indicate any history for the following conditions

[ ] Blindness
[ ] Cataract
[ ] Glaucoma
[ ] Macular Degeneration
[ ] Retinal Detachment/Disease

How many hours per day do you use a computer?

Contacts:

If no, are you interested in contacts?

If yes, what type of lenses?

[ ] Disposable soft
[ ] Regular soft
[ ] Gas Permeable
[ ] Other:

Glasses:

[ ] Always
[ ] Computer
[ ] For Reading
[ ] Only while driving
[ ] Sunglasses

Ocular Surgery

Eye Surgery:

Date of Surgery

Type of Surgery:

[ ] Regular soft
[ ] Gas Permeable
[ ] Other:

Medications & Allergies

List all current medications, including vitamins, supplements and birth control:

Are you allergic to any medications?

If yes, please list:

Reactions:

Family Ocular History and Family Systemic History

Indicate any history for the following conditions:

	Mother	Father	Sister	Brother	Grandparent	Child
AIDS/HIV	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Arthritis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Blindness	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cataract	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Glaucoma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Macular Degeneration	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Retinal Detachment/Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Social History

Do you use tobacco products?

Do you drink alcohol?

Do you use other substances?

Do you participate in sports?

If yes, please list:

Other Health Problems:

Have you had any operations? Yes / No

When?