Eyecare Center of Wheeling
Patient History and Information

Patient Name:_____
Date:_____

What is the primary reason for your visit today? _____
When was your last eye exam?_____ Primary vision correction? _____
Contact lens wearer? ○ Yes ○ No Type of contacts: _____
Wear time:_____ Disposal:_____ Solution: _____

PATIENT EYE HISTORY

Cataracts	○ Yes ○ No	Foreign body	○ Yes ○ No	LASIK/PRK	○ Yes ○ No	Glaucoma	○ Yes ○ No
Cataract surgery	○ Yes ○ No	Glaucoma	○ Yes ○ No	Macular Degeneration	○ Yes ○ No	Cataracts	○ Yes ○ No
Amblyopia (Lazy eye)	○ Yes ○ No	Halos	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	Macular Degeneration	○ Yes ○ No
Dry eye	○ Yes ○ No	Headaches	○ Yes ○ No	Tearing	○ Yes ○ No	Retinal Detachment	○ Yes ○ No
Flashes of light	○ Yes ○ No	Infection	○ Yes ○ No	Trauma	○ Yes ○ No	Amblyopia (Lazy Eye)	○ Yes ○ No
Floaters	○ Yes ○ No	Itchy eyes	○ Yes ○ No	Color Blindness	○ Yes ○ No	Blindness	○ Yes ○ No

PATIENT MEDICAL HISTORY

Diabetes	○ Yes	○ No	Diabetes	○ Yes ○ No
Year diagnosed:_____	Recent blood sugar:_____	HbA1C:_____		
Hypertension	○ Yes	○ No	Hypertension	○ Yes ○ No
High Cholesterol	○ Yes	○ No	High Cholesterol	○ Yes ○ No
Thyroid Disease	○ Yes	○ No	Thyroid Disease	○ Yes ○ No
Cardiovascular Disease	○ Yes	○ No	Cardiovascular Disease	○ Yes ○ No
Cancer	○ Yes	○ No	Cancer	○ Yes ○ No
Other _____			Other	

FAMILY EYE HISTORY

FAMILY MEDICAL HISTORY

REVIEW OF SYSTEMS

General			
○ None	○ Fatigue	○ Fever	○ Pregnant/Nursing
Ear, Nose, Throat			
○ None	○ Cough/congestion	○ Dry mouth	○ Runny nose
Cardiovascular			
○ None	○ Heart disease	○ High cholesterol	○ High blood pressure
Respiratory			
○ None	○ Asthma	○ Bronchitis	○ COPD

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Genital, kidney and bladder			
○ None	○ Kidney problems	○ Other:_____	
Muscles, bones and joints			
○ None	○ Arthritis	○ Other:_____	
Gastrointestional			
○ None	○ Crohns disease	○ IBS	○ Other:_____
Skin			
○ None	○ Eczema	○ Itching	○ Rosacea
Neurological			
○ None	○ Headaches	○ MS	○ Seizures
Psychiatric			
○ None	○ ADHD	○ Anxiety	○ Depression
Endocrine			
○ None	○ Type I diabetes	○ Type II diabetes	○ Hyper/hypothyroid
Allergic/Immunologic			
○ None	○ Seasonal	○ Other:_____	

MEDICATION ALLERGIES

_____

_____

_____

CURRENT MEDICATIONS (attach list if necessary)

_____ _____

_____ _____

_____ _____

Primary Care Physician Address Phone Number

SOCIAL HISTORY

Occupation:_____ **Employer:**_____

Smoking status: ○ **Never smoker** ○ **Current smoker** ○ **Former smoker**

Hobbies:_____