WILSON EYECARE
A MEMBER OF VISION SOURCE

WELCOME TO OUR OFFICE

This confidential case history form is critical to the evaluation of your vision and health.

Today's Date _____

PATIENT INFORMATION

Name _____MI___
Date of Birth _____Age _____

Mailing Address_____
_____
City _____State____Zip Code_____
Home Phone _____
Work Phone _____
Cell Phone _____
Patient's SSN _____

Employer (or School) _____
Occupation (or Grade) _____

Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Email Address _____

What is the major purpose of this visit?
_____
Any problems with your current contact lenses or glasses?
_____
_____

Who may we thank for referring you to our office?
Name of friend or relative _____

Filled out by [ ] Self [ ] Other _____
Relationship:_____

I give permission for _____
to be present during my examination.

Wilson EyeCare Associates Mission:

WE are a professional eyecare team compassionately committed to providing quality vision wellness programs to our precious family of patients.

INSURANCE INFORMATION

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No

How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card ❑ Payment Plan

LIFESTYLE QUESTIONS

Do you……(check box if your answer is yes)
❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in the latest contact lens designs?
❑..spend time outdoors?
How much? ___hours/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser refractive surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have family members in need of eyecare?

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

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

PATIENT MEDICAL HISTORY

Name of Family Physician_____
Town_____
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
Are you pregnant or nursing? ❑ YES ❑ NO
Do you use: Cigarettes ❑ YES ❑ NO
Smokeless Tobacco ❑ YES ❑ NO
Alcohol/Other Substances ❑ YES ❑ NO

Have you ever been diagnosed or treated for the following health problems?	**YES**	**NO**
Allergies	❑	❑
Cancer	❑	❑
Cardiovascular (Blood/Lymph)	❑	❑
Cardiovascular (Cholesterol)	❑	❑
Cardiovascular (High Blood Pressure)	❑	❑
Constitutional (Fatigue, Fevers)	❑	❑
Constitutional (Weight Loss/Gain)	❑	❑
Endocrine (Diabetes)	❑	❑
Endocrine (Thyroid)	❑	❑
Gastrointestinal (Digestive)	❑	❑
Genitourinary (Kidney)	❑	❑
Integumentary (Eczema, Rashes)	❑	❑
Integumentary (Ear, Nose, Throat)	❑	❑
Musculoskeletal (Arthritis)	❑	❑
Neurological	❑	❑
Psychiatric	❑	❑
Respiratory (Asthma)	❑	❑
Respiratory (Bronchitis, COPD)	❑	❑

PATIENT SIGNATURE:
X_____

PATIENT EYE HISTORY

Date of Last Eye Exam_____
By Whom?_____

Do you currently wear contact lenses? ❑ YES ❑ NO

Are you satisfied with the vision and comfort of your contact lenses? ❑ YES ❑ NO

Would you like to discuss your refractive surgery options with Dr. Wilson? ❑ YES ❑ NO

FAMILY MEDICAL/EYE HISTORY (CHECK ALL THAT APPLY)

Is there a family medical history of any of the following?

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

Reviewed by Tech:

_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Wilson EyeCare Associates.

If your insurance company has not reimbursed our office in full within 60 days, you are responsible for providing payment in full to Wilson EyeCare Associates.

Our practice is proud to offer a no fee, 6 month same as cash payment plan. Simply ask and any member of our staff will be happy to assist you with application.