

# WEST WICHITA FAMILY OPTOMETRISTS

## Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

New Patients: How did you hear about our office? \_\_\_\_\_

Responsible Billing Party: \_\_\_\_\_ Phone: \_\_\_\_\_

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

## Medical History

Family Physician: \_\_\_\_\_ Last Physical: \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

List any medical condition for which you are being treated:

List any medications you are taking: (doctor prescribed and over-the-counter)

List any allergies to medicines:

Do you use tobacco products? yes / no If yes, type and amount: \_\_\_\_\_

Women: pregnant? yes / no nursing? yes / no

Check any medical condition that applies to you: (present or past)

<input type="checkbox"/> diabetes	<input type="checkbox"/> cancer	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> high cholesterol
<input type="checkbox"/> head injury	<input type="checkbox"/> liver disease	<input type="checkbox"/> asthma	<input type="checkbox"/> infectious disease
<input type="checkbox"/> arthritis	<input type="checkbox"/> heart disease	<input type="checkbox"/> kidney disease	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> migraine	<input type="checkbox"/> lung disease	<input type="checkbox"/> vascular disease	
<input type="checkbox"/> other:			

Check any eye condition that applies to you: (present or past)

<input type="checkbox"/> eye disease	<input type="checkbox"/> eye surgery	<input type="checkbox"/> eye injury	<input type="checkbox"/> vision therapy
<input type="checkbox"/> turned eye	<input type="checkbox"/> lazy eye	<input type="checkbox"/> glaucoma	<input type="checkbox"/> eye medication
<input type="checkbox"/> cataracts	<input type="checkbox"/> flashing lights	<input type="checkbox"/> double vision	<input type="checkbox"/> laser treatment
<input type="checkbox"/> macular degeneration	<input type="checkbox"/> other:		

## Family History

Check conditions that are present in family members:

<input type="checkbox"/> cataracts	<input type="checkbox"/> diabetes	<input type="checkbox"/> cancer	<input type="checkbox"/> retinal detachment
<input type="checkbox"/> glaucoma	<input type="checkbox"/> stroke	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> blindness	<input type="checkbox"/> macular degeneration	<input type="checkbox"/> other:	

**PLEASE TURN OVER AND COMPLETE SIDE TWO.**

