Kevin B. Wynne O.D.

PLEASE PRESENT ALL INSURANCE INFORMATION TO OUR FRONT OFFICE STAFF

Date _____
Patient's Name _____
DOB _____/_____/_____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____-_____ Home
(_____)_____-_____ Cell
(_____)_____-_____ Work
Insurance _____
Policy # _____
Subscriber _____
Subscriber DOB _____/_____/_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Employer _____
Occupation _____
Emergency Contact Name _____
Phone (_____)_____-_____
Date of Last Eye Exam _____/_____/_____
Date of Last PCP Visit _____/_____/_____
Name of PCP Doctor _____
How did you hear about our office? _____
_____

Miscellaneous

List any previous surgeries with dates
_____
_____
_____

Are you Pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Hobbies/Recreational Sports you enjoy? _____
_____
_____
how many hours a day do you use a computer? _____
Do you wear glasses? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
Are you interested in contact lenses? ☐ Yes ☐ No

Do you perform fine or close up work? ☐ Yes ☐ No
Are you bothered by glare from:
Overhead lighting? ☐ Yes ☐ No
A computer screen? ☐ Yes ☐ No
Oncoming headlights at night? ☐ Yes ☐ No
Are you sensitive to bright sunlight? ☐ Yes ☐ No
Do your eyes feel dry, sore or tired? ☐ Yes ☐ No
Do you use artificial tears? ☐ Yes ☐ No

REVIEW OF SYSTEMS (Do you currently have, or have you ever had, any of the following problems or conditions?)

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐
Ears/Nose/Mouth/Throat		
Allergies	☐	☐
Sinus Congestion	☐	☐
Dry Mouth / Throat	☐	☐
Respiratory		
Asthma	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐

	Yes	No
Gastrointestinal		
Crohn's Disease	☐	☐
Hepatitis A, B, C	☐	☐
Ulcer / Reflux	☐	☐
Genito-Urinary		
Bladder / Genital / Kidney	☐	☐
Herpes Simplex	☐	☐
Prostate	☐	☐
Musculoskeletal		
Joint / Muscle Pain	☐	☐
Osteo Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Integumentary (Skin)		
Skin Cancer	☐	☐
Skin Disease	☐	☐
Shingles	☐	☐
Psychiatric		
Anxiety / Depression	☐	☐

	Yes	No
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
Endocrine		
Diabetes Type I	☐	☐
Diabetes Type II	☐	☐
Thyroid / Other Glands	☐	☐
Lymphatic- Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic / Immunologic		
Eczema	☐	☐
Hives	☐	☐
Lupus	☐	☐
Organ Transplant	☐	☐

OCULAR HISTORY **(mark yes or no for each question)**

Age-related Macular Degeneration	☐ **Yes**	☐ **No**	Injury to the eye region	☐ **Yes**	☐ **No**
Amblyopia (Lazy Eye)	☐ **Yes**	☐ **No**	Keratoconus	☐ **Yes**	☐ **No**
Blindness	☐ **Yes**	☐ **No**	Retinopathy	☐ **Yes**	☐ **No**
Glaucoma	☐ **Yes**	☐ **No**	Strabismus (Crossed Eyes)	☐ **Yes**	☐ **No**
Cataracts	☐ **Yes**	☐ **No**	Tear Film Insufficiency (dry eyes)	☐ **Yes**	☐ **No**
			Other: _____		

PATIENT'S PAST MEDICAL HISTORY **(mark yes or no for each question)**

Arthritis	☐ **Yes**	☐ **No**	Heart disease	☐ **Yes**	☐ **No**
Rheumatoid arthritis	☐ **Yes**	☐ **No**	Hypercholesterolemia (high cholesterol)	☐ **Yes**	☐ **No**
Asthma	☐ **Yes**	☐ **No**	Hypertensive disorder (Hypertension)	☐ **Yes**	☐ **No**
Cancer	☐ **Yes**	☐ **No**	Seasonal Allergy	☐ **Yes**	☐ **No**
Chronic obstructive lung disease (COPD)	☐ **Yes**	☐ **No**	Thyroid dysfunction	☐ **Yes**	☐ **No**
Diabetes mellitus	☐ **Yes**	☐ **No**	Mental disorder	☐ **Yes**	☐ **No**
Emphysema	☐ **Yes**	☐ **No**	Human Immunodeficiency virus infection	☐ **Yes**	☐ **No**

FAMILY HEALTH HISTORY **(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)**

Amblyopia (Lazy eye)	☐**Yes**	☐**No**	_____	Strabismus (crossed eyes)	☐**Yes**	☐**No**	_____
Cataract	☐**Yes**	☐**No**	_____	Diabetes mellitus	☐**Yes**	☐**No**	_____
Glaucoma	☐**Yes**	☐**No**	_____	Cardiovascular disease	☐**Yes**	☐**No**	_____
Macular Degeneration	☐**Yes**	☐**No**	_____	Stroke	☐**Yes**	☐**No**	_____
Blindness and/or vision impairment	☐**Yes**	☐**No**	_____	Hypertension (High Blood pressure)	☐**Yes**	☐**No**	_____
Retinal Disorder	☐**Yes**	☐**No**	_____				

SOCIAL HISTORY **(check one for each question)**

Are you a drug user? ☐ Yes ☐ No

Are you a: ☐ non- drinker ☐ social drinker

TOBACCO USE **(mark which one applies)**

☐ Heavy tobacco smoker ☐ Light tobacco smoker

☐ Never a smoker ☐ Former smoker

MEDICATIONS (attach add'l sheet if necessary)

_____

_____

_____

_____

_____

☐ **No Medications**

MEDICATION ALLERGIES

_____

_____

_____

☐ **No Medication Allergies**

Dr. Signature _____ Date _____

Dr. Initial _____ Review Date _____

Dr. Initial _____ Review Date _____

Dr. Initial _____ Review Date _____