

Visions Plus

204 S Durbin St Casper, WY 82601
Dr. Emily Meihak Stickelberger, OD
VisionsPlusWY.com

Name: _____ Today's Date _____
Email Address _____

Personal Medical History:

Do you currently wear glasses? Y / N If so, how old is your current pair? _____

Are you having trouble with your vision? Y / N If yes, please explain _____

What brings you into our office today? _____

Do you wear contact lenses? Y / N Are you interested in contacts? Y / N

Date of last eye exam _____ Name of Doctor _____

Date of last Medical exam _____ Name of Doctor _____

Doctor phone number _____ Name of pharmacy _____

Please mark if **you** OR your **family members** have any of the following conditions:

Self/Family/none

Diabetes

High Blood Pressure

High Cholesterol

Thyroid Disease (hyper/hypo)

Heart Disease

Self/Family/none

Cancer

Glaucoma

Cataracts

Macular Degeneration

Other

Are you pregnant or nursing? Y / N

Please list any medications you are taking (including over the counter) (NONE)

Please list any known drug allergies (NONE)

Please list any previous **eye surgeries** with dates: _____

For Office Use Only-

Insurance/Self _____