VISIONS PLUS

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VisionsPlusWY.com

Name:____ Today's Date _____________

Email Address____

Personal Medical History:

Do you currently wear glasses? Y / N If yes, 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? ____

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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 _________________________

Please mark if **YOU** or your **FAMILY MEMBERS** have any of the following conditions:

Self/Family/none				Self/Family/none			
☐	☐	☐	Diabetes year of diagnosis _____	☐	☐	☐	Cancer
☐	☐	☐	High Blood Pressure	☐	☐	☐	Glaucoma
☐	☐	☐	High Cholesterol	☐	☐	☐	Cataracts
☐	☐	☐	Thyroid Disease (hyper/hypo)	☐	☐	☐	Macular Degeneration
☐	☐	☐	Heart Disease	☐	☐	☐	Retinal Disease

☐ ☐ ☐ Auto Immune Disease please explain _________________________________

☐ ☐ ☐ Other please explain ____

Are you pregnant? Y / N If yes, due date ______ Are you nursing? Y / N

For patients 14 and older: (some insurance carriers require this information)

Do you use tobacco products? Y / N If yes, type/amount/how often? _______________

Do you drink alcohol? Y /N If yes, type/amount/how often? ______________________

Do you use illegal drugs? Y / N If yes, type/amount/how often? ____________________

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

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Please list any known drug allergies (NONE)

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Please list any previous **eye surgeries** with dates (ie cataract surgery, lasik/PRK/RK refractive surgery, strabismus surgery, eyelid surgery, retinal surgery):

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