WisconsinVision
YOU WON'T BELIEVE YOUR EYES.™

PATIENT HEALTH HISTORY

Date: _____

Patient Name (Print): _____ DOB_____/_____/_____ Email: _____

Address: _____ City:_____ State: _____ Zip: _____ Phone Number:_____

Primary Care Physician: _____ Occupation: _____ Gender: M / F

Due to current Federal Medical Guidelines, we are required to obtain the following information

Preferred Language: English / Spanish **Preferred Communication Preference**: Email / Postal Mail / Telephone
Race: Black/African American, American Indian/Alaska Native, Hispanic, Asian, White, Native Hawaiian/Other Pacific Islander
Ethnicity: Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Not Hispanic or Latino

What is the main reason for your visit today? _____ **Do you wear?** Contacts / Eyeglasses **Are you interested in contacts?** Y / N

Medical/Family History

Please list current medications:_____

_____

List any allergic reactions to **medications or eye drops**: _____

_____

Women – Are you pregnant? Y / N

Please indicate if any of the conditions apply:

Disease/Condition	**Yourself** Yes	No		**Family Member** Yes	No	Relationship (Blood Relatives Only)
Cataract	☐	☐	Blindness	☐	☐	_____
Eye Turn	☐	☐	Eye Turn	☐	☐	_____
Glaucoma	☐	☐	Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	Retinal Detachment	☐	☐	_____
Eye Surgery	☐	☐				
Eye Injury	☐	☐				

Other:_____

Are you diabetic? Y/N If so, what year were you diagnosed? _____ What was your blood sugar today? _____
What is your most current HbA1C? _____

Review of Systems Please indicate below (circle) if you have any of the following conditions:

Social Tobacco Use: Current Smoker / Former Smoker / Non-Smoker Non-prescription drugs Alcohol Consumption

Allergic/Immunologic
Lupus (SLE)
Rheumatoid Arthritis
Environmental Allergies
Seasonal Allergies
Other (i.e., Latex)

Ear, Nose and Throat
Sinusitis
Upper Respiratory
Tract Infection
Other

Gastrointestinal
Crohn's Disease
Colitis
Acid Reflux/Ulcer
Other

Skin/Integumentary
Eczema
Rosacea
Psoriasis
Other

Psychiatric
Depression
Bi-Polar
Schizophrenia
Other

Cardiovascular
High Blood Pressure
Heart Disease
Stroke
Vascular Disease
High Blood Cholesterol

Endocrine/Glands
Diabetes
Hormone Dysfunction
Thyroid Dysfunction
Other

Respiratory
Asthma
Bronchitis
Emphysema
Other

Muscle/Skeletal
Arthritis
Fibromyalgia
Ankylosing Spondylitis
Other

Genital/Urinary
Urinary Tract
Infection
HIV Positive
Herpes/Chlamydia
Other

Hematologic/Lymphatic
Anemia
Leukemia
Bleeding Disorder
Other

Neurological
Multiple Sclerosis
Epilepsy
Tremors
Other

General Health
Weight loss/gain
Fever
Fatigue
Trauma

Insurance Information: Are you covered by vision coverage? Y/N If yes, please list: _____

SSN/Insurance #: _____ Do you have secondary vision coverage? _____

At Wisconsin Vision we will make every effort to check your eligibility with your insurance carrier. Because of the ever-changing information with insurance companies and/or circumstances beyond our control, WE CANNOT GUARANTEE THAT YOUR VISION BENEFITS WILL ALWAYS COVER PART OR ALL OF YOUR PURCHASES FROM US. You will be responsible for any unpaid balance. If you have any concerns regarding your insurance benefits and eligibility, we urge you to contact your insurance carrier before you order products or services from us.

Lifestyle Information: To help us assist you with your eye care needs, please circle all that apply:

Boating/Fishing Computer use (give % of time each day _____) Shooting Golfing Motorcycling Bicycling
Participate in Sports Swimming Driving Hunting Close-up work Woodworking Use of Power Tools
Intermediate Work Gardening Reading Hiking Other:_____

Please sign to acknowledge this form is current and that you received a copy of Wisconsin Vision, Inc.'s Notice of Privacy Practices.

Patient's Signature or legal guardian : _____ Date: _____

Reviewed by Doctor's initials: _____

FOR OFFICE USE:

Eyeglasses 1: Date :_____

OD_____ Add: _____ Type: _____

OS _____ Add: _____ Material: _____
Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Eyeglasses 2: Date: _____

OD_____ Add: _____ Type: _____

OS _____ Add: _____ Material: _____
Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Contact Lenses:

Brand: _____ OD_____

BC: _____ OS _____

New Contact lens or trials

Brand: _____ OD_____

BC: _____ OS _____

Based on the patient's lifestyle, prescription and ocular health needs, what products do you recommend? (completed by Optometrist)

Teflon Coating / Prescription Sunglasses / Back-up pair of eyeglasses for contact lens wearers / Progressive No-Lines

Polarized / UV protection / Multiple Pair

Additional Notes:

_____

_____

_____

_____