WISE EYES
OPTICAL & VISION CENTER

Dr. Martin Wiesenthal
Board Certified Optometrist

PATIENT HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____ City: _____ Zip: _____

Phone Numbers:

Home Phone No: _____ Work Phone No: _____ Cell Phone No: _____

SSN: _____ Driver's License No: _____ Date Of Birth: _____ Age: _____

Occupation: _____ Employer: _____

Emergency Contact/Telephone: _____ Spouse/Parent: _____

Date Of Last Exam: _____ Dilated?: ☐Y ☐N Previous Eye Doctor: _____

The Reason For My Visit Today Is: _____

Do You Have A Medical Expense Account?: ☐Y ☐N Usage Deadline Date?: _____

I Want To Discuss:

☐Eye Glasses ☐Contact Lenses ☐Sports Eye Protection ☐Sunglasses ☐LASIK ☐Prescription Sunglasses

Whom May We Thank For Referring You? _____

Can We Dilate Your Eyes Today? ☐Y ☐N Email Address: _____

MEDICAL INFORMATION

What Is Your General Health?: _____

Do You Have Any Problems With Any Of These Systems?:

☐Eye ☐Mental ☐Respiratory ☐Endocrine ☐Gastrointestinal ☐Ears/Nose/Throat ☐Skin

☐Lymph ☐Nervous ☐Genitourinary ☐Immunologic/Allergy ☐Musculoskeletal ☐Cardiovascular

Please Explain:

Please Answer All That Apply:

Diabetes: ☐Y ☐N _____ *Type* _____ *Diagnosis*

Medical Allergy: ☐Y ☐N _____ *What Happens?*

Allergies: ☐Y ☐N _____ *Allergic To What?* _____ *What Happens?*

Headaches: ☐Y ☐N _____ *Other Health Problems* _____ *Current Medication(s)*

Have You Had Any Operations? ☐Y ☐N _____ *Kind?*

Do You Use Cigarettes/Tobacco? ☐Y ☐N

Alcohol? ☐Y ☐N

Other Substances ☐Y ☐N

Family Doctor: _____ Date Of Last Visit: _____ Date Of Last Tetanus Shot: _____

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FAMILY HISTORY

High Blood Pressure ☐Y ☐N _____ *Relation*

Diabetes ☐Y ☐N _____ *Relation*

Glaucoma ☐Y ☐N _____ *Relation*

Other Eye Condition(s) ☐Y ☐N _____ *What Kind?* _____ *Relation*

Macular Degeneration: ☐Y ☐N _____ *Relation*

Retinal Detachment: ☐Y ☐N _____ *Relation*

Cataracts: ☐Y ☐N _____ *Relation*

PERSONAL INFORMATION

Eye Operations? ☐Y ☐N _____ *Type* _____ *Date*

Eye Injury? ☐Y ☐N _____ *Kind* _____ *Date*

Do You Have Glaucoma? ☐Y ☐N

Cataracts? ☐Y ☐N

Dry Eyes? ☐Y ☐N

Blurred Vision? ☐Y ☐N

Do You Wear Glasses? ☐Y ☐N

Contacts? ☐Y ☐N _____ *Type/Brand:*

Hobbies/Interests? _____

Thank You For Choosing Dr. Martin Wiesenthal And Wise Eyes Optical.