#_____

Wagoner Family Eye Care, PLLC
R. Luke Wagoner, O.D.
3701B Old Forest Road
Lynchburg, Virginia 24501

Patient Name _____ Date _____

The information in this confidential case history form is critical to the evaluation of your vision and health

**********************PATIENT MEDICAL HISTORY**********************

Primary Care Physician _____ Date of Last Check-up _____
Current Medications (Rx and/or over the counter) Please list names of medications including eye drops, vitamins and birth control pills _____
_____
_____

Allergies to medications? ☐ Yes ☐ No If so, what medications? _____
Do you use cigarettes/tobacco? ☐ Yes ☐ No If so, how much? _____
Do you use alcohol? ☐ Yes ☐ No If so, how much and/or how often? _____
Have you had any surgeries? ☐ Yes ☐ No If so, what type and when? _____

Have you ever been diagnosed or treated for the following health problems?

☐ Allergies	☐ Arthritis	☐ Blood/Lymph	☐ Bronchitis
☐ Cancer	☐ Cholesterol	☐ Diabetes	☐ Digestive
☐ Ears/Nose/Throat	☐ Endocrine	☐ Eczema/Rashes	☐ Fatigue
☐ Fevers	☐ Genitourinary	☐ High Blood Pressure	☐ Integumentary
☐ Kidney	☐ Muscle/Bone	☐ Neurological	☐ Psychological
☐ Respiratory	☐ Sinus	☐ Throat Infections	☐ Thyroid
☐ Unusual weight loss/gain			

**********************PATIENT OCULAR HISTORY**********************

Date of last eye exam _____ By Whom? _____
Do you currently wear eyeglasses? ☐ Yes ☐ No
If so, when? For distance _____ for near _____ all the time _____
Do you currently wear contact lenses? ☐ Yes ☐ No Solutions used? _____
What type of contacts? Daily Wear _____ Extended Wear _____ Replacement _____
Wearing schedule? _____ Replacement schedule? _____

Have you ever been diagnosed or treated for the following ocular problems?

☐ Cataracts	☐ Corneal Abrasions	☐ Strabismus	☐ Eye Infection
☐ Eye Injury	☐ Glaucoma	☐ Iritis/Uveitis	☐ Amblyopia
☐ Macular Degeneration	☐ Retinal Detachment	☐ Other _____	

Have you ever had any ocular surgeries? ☐ Yes ☐ No
What type? When? Which eye? _____

**********FAMILY MEDICAL/OCULAR HISTORY**********

Is there a family medical history of any of the following? ☐ Yes ☐ No

		(Relationship)			(Relationship)
Blindness	☐	_____	Cataracts	☐	_____
Corneal Problems	☐	_____	Glaucoma	☐	_____
Lazy Eye	☐	_____	Macular Degeneration	☐	_____
Retinal Problems	☐	_____	Diabetes	☐	_____
Heart Disease	☐	_____			

**********PATIENT LIFESTYLE**********

Do any of the following apply to you?

☐ Work at a computer? If so, how many hours per day? _____
☐ Prefer not to wear eyeglasses at times?
☐ Have an interest in a "test drive" of the latest contact lens designs?
☐ Want information on Laser Vision Correction surgery?
☐ Spend time outdoors? How many hours per week? _____
☐ Are you involved in sports? If so, what type of sports? _____
☐ Have family members in need of eye care?

**********REASON FOR YOUR VISIT**********

It is our mission to provide you with the highest quality of vision care. In order to better serve you we need to have a full understanding of the reason for today's visit.

A routine vision exam always includes your prescription for eyeglasses, a functional assessment and an ocular health assessment. It does <u>not</u> include treatment for ocular disease and/or injury nor does it include contact lens fitting and/or evaluation. Understanding this statement, please provide (in your own words) the major purpose of today's visit: _____
_____
_____
_____
_____

If you are having an ocular health related problem, are you experiencing any of the following?

☐ Blurry Vision	☐ Burning	☐ Double Vision	☐ Flash of Light-Floaters/Spots
☐ Grittiness	☐ Headaches	☐ Itchiness	☐ Dryness
☐ Sunlight Sensitivity	☐ Tearing	☐ Trouble seeing at night	
☐ Other _____			

Signature _____ Date _____