BARNETT WAMBOLDT EYECARE
6116-39 Avenue Kenosha, WI 53142
Ph.262-653-0100 Fax 262-653-0200

PERSONAL INFORMATION: Date_____

Last Name_____ First Name_____ MI____ Birth date_____

Address_____City_____ State_____ Zip_____ Phone_____

Email_____Occupation/ Hobbies_____ How did you hear about our office?_____

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MEDICAL HISTORY (please check if you have or had any of the following):

Cardiovascular
____High Blood Pressure
____Heart Disease
____Stroke
____Circulation Problems

Respiratory
____Asthma
____Bronchitis
____Emphysema

Endocrine
____Diabetes
____Thyroid Problem
____Hormone Problem

Gastrointestinal
____Ulcer
____Crohn's Disease
____Colitis

Genitourinary
____Kidney Problems
____Urinary Tract Infection
____STD-viral,herpetic,chlamydia

Constitutional
____developmental disability
____weight loss
____fever
____fatigue
____trauma

Psychiatric
____Depression
____Panic Disorder
____Schizophrenia

Muscoloskeletal
____Fibromyalgia
____Osteoporosis
____Muscular Dystrophy
____Osteoarthritis
____Gout

Hematologic/Lymphatic
____Anemia
____Leukemia

Neurologic
____Multiple Schlerosis
____Epilepsy
____Parkinson's
____Cerebral Palsy
____Myasthenia Gravis

Skin
____Eczema
____Rosacea
____Psoriasis

Ear, Nose, & Throat
____Upper Resp. Tract Inf

Allergy/Immunology
____Rheumatoid Arthritis
____Lupus

Cancer:_____
Other:_____
Medications:_____
_____
Allergies:_____

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Social History--- Do you use any of these: Tobacco products? No Yes Alcohol ? No Yes Illegal drugs? No Yes
Have you ever been exposed to or infected with? ____Hepatitis ____HIV

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Family Medical History: ____Diabetes ____High Blood Pressure ____Glaucoma ____Macular Degeneration ____Blindness

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VISION HISTORY:

What is your reason for today's visit?_____

Please check those which you feel are problems:

____Blurry vision
____Headaches
____Floating spots
____Flashes of light
____Burning
____Itching
____Watering
____Redness
____Sensitivity to light
____Gritty feeling
____Dryness
____Halos around lights
____Sudden vision loss
____Double vision
____Tire easily
____Other_____

Have you had any of the following::

____Glaucoma
____Cataracts
____Macular degeneration
____Eye injury
____Eye surgery
____Eye infection
____Head injury
____Other_____

____Wear glasses----if yes , please check: ____Reading ____Distance ____At all times
____Wear contact lenses----if yes, please check: ____Soft ____Gas-permeable How old are your lenses?_____

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Patient Signature:_____ Date:_____

Authorization of insurance payment to Barnett Wamboldt Eyecare:_____
Vision Insurance Carrier:_____

Reviewed by:_____
Date:_____