Wilsonville Vision Center
Welcome To Our Office

Welcome To Wilsonville Vision Center. Thank You For Choosing Us For Your Eyecare Needs. We Are Delighted To Have You As A Patient And Appreciate The Confidence You Placed In Us. Please Take A Moment To Complete The Following Information. Any Information We Already Have On File Will Appear On This Form. Please Review All Completed Areas To Ensure That The Information We Have Is Current And Accurate. If You Have Any Questions, Please Do Not Hesitate To Ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State Zip ______

Social Security Number ______ Date of Birth ______ Home Phone - Include Area Code ______ Work Phone ______

Email Address ______ Spouse or Parent(s) Name ______ Person Responsible for Account ______

What is the main reason for today's exam ? ______ When was your last exam ? ______

How were you refered to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) ______

☐ Insurance Listing ☐ Drive by ☐ Other ______ ☐ Doctor (Please Name) ______

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name ______

Address of Primary Care Physician ______ City ______ State Zip ______ Phone ______

Medicines that cause reactions: ______

Current Eye Drops: ______

Specific Allergies: ______

Current Medications: ______

Past Illnesses or Injuries: ______

Past Surgeries: ______

Are you either?

☐ Pregnant
☐ Nursing

SPECTACLE LENS HISTORY

Are your sun glasses your current prescription ? ○ Yes ○ No

Current Occupation : ______ Years ______ Employer ______

Do you use a computer? ○ Yes ○ No How many hours/day? ______

Do you have glare problems? ○ Yes ○ No

Have you had trouble in the past with glasses? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you wear sunglasses? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since ______

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? ____________

Do you currently wear contact lenses? ○ Yes ○ No Since ____________

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Type and brand of contact lenses ____________ Today's wearing time ? ______

How many hours/day ? ________ How many days/week ? ________

What Solutions do you use? ____________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Hobbies/ Interests : ____________

MEDICAL HISTORY QUESTIONAIRE

EYE HISTORY

Condition	Response	Condition	Response	Condition	Response
Headaches	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Itching	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Double Vision	○ Yes ○ No
Burning	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Dryness	○ Yes ○ No	Redness	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Excess Tearing/Watering	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Eye Pain or Soreness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No

GENERAL HEALTH CONDITION

Condition	Response	Condition	Response	Condition	Response
Diabetes	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Skin	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Neurological	○ Yes ○ No
Other Systems	○ Yes ○ No	Kidney	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Endocrine	○ Yes ○ No
Weight Loss	○ Yes ○ No			Blood/Lymph	○ Yes ○ No

FAMILY HISTORY

Condition	Response	Condition	Response	Condition	Response
Amblyopia (Lazy Eye)	○ Yes ○ No	Mac Degen	○ Yes ○ No	Diabetes	○ Yes ○ No
Blindness	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	Heart Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	High B.P.	○ Yes ○ No
Color Blindness	○ Yes ○ No	Arthritis	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Glaucoma	○ Yes ○ No	Cancer	○ Yes ○ No	Lupus	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Other	○ Yes ○ No	Stroke	○ Yes ○ No