Steve Wexler, OD
goodworks eyecare

Member American Optometric Association

PATIENT HISTORY FORM

STEVE WEXLER, OD 3900 FOUNTAIN SQ. PL. WAUKEGAN, IL 60085 847-473-2568

Name _____ Birth Date _____ Age _____ Today's Date _____

Address _____ City _____ State ____ Zip Code _____

Phone(CELLULAR) (_____)_____ HOME or WORK PHONE(_____)_____

Email (For your annual exam reminder) _____ Occupation _____

Are you using vision insurance for payment of your eye exam? ☐yes ☐No ---I'll pay by cash, credit or check.
Do you have Medicaid, Public Aid, All Kids, Illinois Medical Card? ☐yes ☐No

What is the main reason for your examination today? _____
When was your last eye examination? _____ ☐Unknown ☐First examination

Where was your last examination? _____ Are you interested in Laser Vision Correction (LASIK)? ☐Yes ☐No

Do you have children? ☐No ☐Yes--- What are their current ages? ____ , ____ , ____ , ____ , ____

Have you worn contacts? ☐No ☐Yes--What brand name? _____ Soft contacts? ☐Yes ☐No

When was the last time you wore your contact lenses? ☐I just took them off before the exam. ☐_____

MEDICATIONS AND ALLERGIES

Are you taking any medications (prescription or over-the-counter)? ☐No ☐Yes--Please list all your medications. If you have a written list, please bring the list to the examination. My medications:

_____

Do you have allergies to medications? ☐No ☐Yes-- I am allergic to _____

Do you have allergies to the environment or other things? ☐No ☐Yes, they are _____

THE HEALTH OF YOU AND YOUR FAMILY

Please place an **X** in the boxes that apply to YOU or your FAMILY MEMBERS concerning the conditions below:

BODY SYSTEM	YOU	FAMILY
Diabetes	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Respiratory/Asthma	☐	☐
Heart problems	☐	☐
Thyroid	☐	☐
Arthritis	☐	☐
Lupus	☐	☐
Crohn's	☐	☐
Sarcoidosis	☐	☐
Depression or anxiety	☐	☐
Tuberculosis	☐	
Multiple Sclerosis	☐	
HIV or AIDS	☐	
Headaches often	☐	
Brain Surgery	☐	
Head trauma	☐	
Hospitalization in last 2 years	☐	
Pregnancy in last 12 months..	☐	

EYE SYSTEM	YOU	FAMILY
Glaucoma	☐	☐
Cataracts (clouded lens in eye)	☐	☐
Double vision	☐	☐
Eye surgery	☐	☐
Wandering or drifting eye	☐	☐
Lazy eye (amblyopia)	☐	☐
Blindness	☐	☐
Macular degeneration	☐	☐
Retinal detachment	☐	☐
Spots (clear, black or red) in vision	☐	
Blurry at distance with glasses	☐	
Eye trauma	☐	
Flashes of light in your vision	☐	
Difficulty with night vision	☐	
Bothered by sun or bright lights	☐	
Eyes burn, itch or water	☐	
Use any kind of eye drops	☐	
Eyes bothered by blowing air	☐	
Work on a computer terminal	☐	

****PLEASE EXPLAIN ANY OTHER MEDICAL OR EYE CONDITION(S) YOU HAVE THAT ARE NOT LISTED ABOVE**

_____