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

_____

Patient Name _____ Date _____

Patient Medical History

Primary Care Physician _____ Date of Last Check-up _____

Have you ever been diagnosed or treated for any of 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	☐ Other	☐ Other	☐ Other

Current Medications (Rx and/or over the counter). Please list names of medications including eye drops, vitamins, and birth control pills.

_____

_____

Patient Ocular History

Date of last eye exam _____

Do you currently wear eyeglasses? ☐ Yes ☐ No

If so, when? ☐ For distance ☐ For near ☐ All the time

Do you currently wear contanct 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 any of the following ocular problems?

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

List any eye surgeries: 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	☐ _____	Thyroid Disorder	

Do any of the following describe you? ☐ Yes ☐ No

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

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 glasses at times?
- ☐ Have an interest in a "test drive" of the latest contact lens designs?
- ☐ 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 hightest quality 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 not include treatment for ocular disease and/or injury nor does it include contact les fitting and/or evaluation. Understanding this statement, please provide (in your own words) the major purpose of today's visits:

_____

_____

_____

_____

_____

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 of Patient, Guardian or Personal Representative _____

Date _____

Print Name of Patient, Guardian or Personal Representative _____

Relationship to Patient _____