MEDICAL HISTORY

_____ _____

Name Age

Reason for appointment: _____

_____

Do you or a family member have a past history of any of the following eye conditions? Please check all that apply and note who is/was affected by condition.

Yes	Condition	Self or family member?	Yes	Condition	Self or family member?
	Astigmatism			Far-Sightedness	
	Bleeding in Eye			Floaters or Flashes	
	Cataract			Glaucoma	
	Corneal Disease			Iritis	
	Diabetic Eye Disease			Lazy Eye	
	Eye Allergies			Macular Degeneration	
	Eye Infection			Migraine	
	Eye Injury			Near-Sightedness	
	Eye Muscle Problems			Retinal Detachment	
	Eye Surgery			Retinal Tear	

Do you wear glasses? □ No □ Yes, if yes are they for □ distance □ reading □ both

_____ _____

Date of last eyeglass exam Name of previous ophthalmologist or optometrist

Do you currently wear contact lenses? □ No □ Yes _____

Brand and type of contact lenses

Gene E. Wyll, M.D., P.A., 610 North Coit, Suite 2115, Richardson, Texas 75080

MEDICAL HISTORY

_____ _____

Date of last contact lens exam Name of previous ophthalmologist or optometrist

Please list any medications to which you are allergic _____

_____

Medical History: Please check all that are applicable for your current personal medical history.

Yes	Condition	Yes	Condition
	AIDS		Hearing Loss
	Anemia		Heart Disease
	Arthritis		Hepatitis
	Asthma		High Blood Pressure
	Bleeding Disorders		High Cholesterol
	Breathing Problems		Kidney Disease
	Cancer		Liver Disease
	Diabetes		Multiple Sclerosis
	Digestive Disorders		Osteoporosis
	Dizziness		Shortness of Breath
	Headaches		Thyroid Disorders

Any other medical condition? _____ Pregnant? □ No □ Yes

Please list any surgery and the year performed: _____

_____

Gene E. Wyll, M.D., P.A., 610 North Coit, Suite 2115, Richardson, Texas 75080

MEDICAL HISTORY

Please list all medications you are presently taking:

_____

Name of Primary Care Physician and address.

Certification: I certify that I have read and understand the information on this form and I have accurately answered all of the questions. I understand that providing incorrect information can be dangerous to my health. I will not hold Gene E. Wyll, M.D. or any member(s) of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (or parent/guardian) Date