WEC 011713

Patient History Update © MIS, LLC

Date:______________________ Patient Name:____________________________________

Date of Birth______________________ SS#_____________________________

Home Phone:______________ Work Phone:_____________ Other Phone:____________

Primary Care Physician:______________________________Phone__________________

Pharmacy Name & Phone____

Authorization to discuss my medical condition:

I authorize ______________________________________ __________________

Name (s) Phone

Relationship(s) to me ________________________ to discuss my medical condition with Dr. Wilkinson, Dr. Smith, Dr. Besirli, Dr. Schmitz or their designee and to obtain test results on my behalf.

Signature:_______________________________________ Date_______________

I have received a copy of the *Wilkinson Eye Center, P.C.* Notice of Privacy Practices for Protected Health Information.

Signature:_______________________________________ Date:_______________

Reason for today's visit: Check all that apply: eye exam for follow up of ☐ cataracts ☐ glaucoma ☐ diabetes ☐ macular degeneration ☐ eye injury ☐ cornea problems ☐ check prescription for glasses / contact lenses ☐ Other____

Have you noticed any changes in your vision since your last visit? Yes____ No____

If Yes, please explain.____

____

Are you interested in LASIK or Refractive Surgery? Yes____ No ____

General Review of Systems:

Do you currently have any of the following?

Diabetes?	Yes___	No___	Allergies?	Yes___	No___
High Blood Pressure	Yes___	No___	High Cholesterol	Yes___	No___
Heart Problems?	Yes___	No___	Weight Loss?	Yes___	No___
Breathing Problems?	Yes___	No___	Skin Problems or Rashes?	Yes___	No___
Stomach or Intestinal Problems?	Yes___	No___	Urinary or Genital Problems?	Yes___	No___
Arthritis or Joint Problems?	Yes___	No___	Neurologic complaints ie: Stroke, Seizure, Weakness	Yes___	No___
Ear, Nose or Throat Problems?	Yes___	No___	Bleeding Tendencies?	Yes___	No___
			Psychiatric Illness?	Yes___	No___

Do you smoke? Yes___ No___

New medical diagnosis since your last visit?_________________________________

List any surgeries you have had <u>since your last visit</u>: ______________________________

Please list your current medications, including over the counter meds and herbal supplements

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________

Please list any allergies to medications:

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________

X______________________________

Patient Signature

____

Physician Signature