4505 E Greenstreet Cir
Wasilla AK 99654
Ph: 907-376-2020
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WOLF EYE CENTER
PATIENT HISTORY FORM

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Evan Wolf, MD PhD

Name_____ DOB _____ Chart #_____ Date _____
Daytime Phone: _____ Primary Care Physician: _____

PERSONAL MEDICAL HISTORY/REVIEW OF SYMPTOMS:

Do you have any problems in the following areas? Or are you taking any medication? (*CIRCLE ALL THAT APPLY*)	**YES**	**NO**
1. **EYES** (poor vision, dry eyes, eye pain, tearing, redness, etc.)		
2. **GENERAL** (fever, weight loss or gain, fatigue, other)		
3. **EAR / NOSE / MOUTH / THROAT** (hearing loss, stuffy nose, dry mouth, other)		
4. **HEART** (chest pain, high blood pressure, irregular heartbeat, other)		
5. **RESPIRATORY** (asthma, shortness of breath, wheezing, coughing, TB, other)		
6. **STOMACH** (stomach upset, diarrhea, constipation, hernia, ulcers, other)		
7. **GENITAL / KIDNEYS / BLADDER** (painful or frequent urination, impotence, other)		
8. **SKIN** (pimples, warts, growths, rashes, other)		
9. **MUSCLE / BONE / JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, other)		
10. **NEUROLOGICAL** (numbness, headaches, seizures, paralysis, other)		
11. **BLOOD / LYMPH** (bleeding, high cholesterol, anemia, blood clot disorder, other)		
12. **FEMALES** (Are you pregnant? Nursing?)		
13. **HORMONE** (thyroid problems, other)		
14. **DIABETES** (If YES, how is it controlled? Circle all that apply: Insulin / Diet / Medications / None)		
15. **PSYCHIATRIC** (depression, anxiety, insomnia, other)		
16. **IMMUNOLOGIC** (sarcoidosis, lupus, iritis, rheumatoid arthritis, Crohn's, Graves, MS)		
17. **INFECTION / VIRUS** (HIV/AIDS, Hepatitis, TB, Shingles, Herpes Simplex, MRSA, other)		

ALLERGIES/CURRENT MEDICATIONS:

Are you allergic to LATEX? □ YES □ NO
Please list all allergies to medications:
Please list all medications you are taking, including eye drops:

EYE HISTORY:

Have you ever had eye surgery? □ YES □ NO
Have you ever had an eye infection? □ YES □ NO
Have you ever had an eye trauma? □ YES □ NO
If yes to any of the above, please explain:_____
_____

FAMILY HISTORY – Has any member of your family had these diseases (CIRCLE ALL THAT APPLY):

	Yes	**No**	**UNKNOWN**
Blindness, Cataracts, Glaucoma, Macular Degeneration, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other heritable disease:			

SOCIAL HISTORY – (CIRCLE ALL THAT APPLY):

	Yes	**No**
Does your vision limit any activities of daily living (driving, reading, sports, work, etc)?		
Have you ever had a blood transfusion?		
Do you drink alcohol? If YES, how much?_____		
Do you smoke? If YES, how much? _____How many years? _____		

CONTACT LENSES	**Yes**	**No**
Do you wear contact lenses?		
I sleep in my contact lenses		
My lenses are □ soft □ rigid gas permeable		
I have worn contact lenses for _____ years		
My cleaning solution is:		
I dispose of contacts every _____weeks/days		

The information above is complete and accurate to the best of my knowledge.

_____ _____
PATIENT or PARENT/GUARDIAN SIGNATURE **Date**

_____ _____ _____ _____
Physician Signature **Date** **Technician Signature** **Date**

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WOLF EYE CENTER
CHILDREN'S HISTORY FORM

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Evan Wolf, MD PhD

Name_____ DOB _____ Chart #_____ Date _____
Daytime Phone: _____
Child's Doctor: _____ Last Exam Date:_____

DOES YOUR INFANT/TODDLER (AGE 0-2):	**Yes**	**No**
Have an eye that turns in or out	□	□
Have excess tearing	□	□
Have red eyes or lids	□	□
Have swelling around the eyes	□	□
Have white appearance in the pupil	□	□

DOES YOUR PRE-SCHOOLER (AGE 3-5):	**Yes**	**No**
Have an eye that ever appears to be out of proper alignment	□	□
Tend to bump into objects	□	□
Have red eyes or lids	□	□
Rub eyes frequently	□	□
Have excess tearing	□	□
Turn or tilt head to use one eye only	□	□
Have encrusted eyelids	□	□
Have frequent styes	□	□
Avoid coloring, puzzles or detailed activities	□	□
Experience difficulty with eye-hand body coordination	□	□

DOES YOUR SCHOOL-AGE CHILD (AGE 6-12):	**Yes**	**No**
Lose place while reading	□	□
Avoid close work	□	□
Hold reading material closer than normal or shift the reading distance	□	□
Tend to rub eyes	□	□
Have headaches	□	□
Turn or tilt head to use one eye only	□	□
Make frequent reversals when reading or writing	□	□
Use finger to maintain place when reading	□	□
Omit or confuse small words when reading	□	□
Consistently perform below potential	□	□
Struggle to complete homework	□	□

FAMILY HISTORY:	**Yes**	**No**
Do any family members have Lazy eye (ambloypia)	□	□
Eye turn (strabismus)	□	□
Eye Tumor	□	□
Other eye or medical problems	□	□

If yes please explain:_____

The information above is complete and accurate to the best of my knowledge.

_____ _____
PARENT/GUARDIAN SIGNATURE **Date**

_____ _____ _____ _____
Physician Signature **Date** **Technician Signature** **Date**