509 Chain Drive, Appleton, WI 54915
Phone: (920) 733-3629, aecinfo@wiinsight.com

251 N Sawyer Street, Oshkosh, WI 54902
Phone: (920) 235-5530, info@wiinsight.com

Health History Questionnaire

Patient Name: _____ **Date:** _____

History:

Reason for visit: _____

Any issues with vision?

- ❑ No
- ❑ Yes: _____

Any issues with comfort?

- ❑ None
- ❑ Dryness, itchiness, redness, or watering? (please indicate what symptom)
- ❑ Other: _____

Are you using any eye drops and what brand?

- ❑ No
- ❑ Yes: _____

Any Flashes of light, floaters, or double vision (diplopia)?

- ❑ No
- ❑ If yes, how long has it been going on and how often?_____

Primary Care Provider: _____at what office:_____

Please list any medications:_____

_____

Allergies:

- ❑ Medication allergies: _____
- ❑ Environmental / Other allergies: _____

Surgical History:

- ❑ None
- ❑ Yes, when and what type: _____

Social History:

Drinking

- ❑ No
- ❑ Yes, amount? _____

Tobacco use

- ❑ No, Never or Former? (circle one)
- ❑ Yes:
  - What type? Cigarettes, cigars, smokeless tobacco, e-cigarettes, vapes
  - How often? _____

Past Ocular History

- ❑ None
- ❑ Yes: _____

Review of Systems:

****If you have any of the following please circle the condition that applies****

Constitution:
- ❏ None
- ❏ Developmental Disabilities, Cancer, Fatigue Syndrom, other: _____

ENT (Ear, Nose, Throat):
- ❏ None
- ❏ Hearing loss, Sinusitis, Dry Mouth, Laryngitis, other: _____

Neurological:
- ❏ None
- ❏ Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraine, Autism, other: _____

Psychological:
- ❏ None
- ❏ Depression, ADHD, ADD, Anxiety, Bipolar, other: _____

Cardiovascular:
- ❏ None
- ❏ Hypertension, Heart Disease, Vascular Disease, Congestive Heart Failure, other: _____

Respiratory:
- ❏ None
- ❏ Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea, other: _____

Gastrointestinal:
- ❏ None
- ❏ Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, other: _____

Genitourinary:
- ❏ None
- ❏ Kidney disease, Prostate cancer/disease, STD, Pregnant, Nursing, Herpes, Chlamydia, other: _____

Musculoskeletal:
- ❏ None
- ❏ Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Spondylitis, Osteoporosis, Gout, other: _____

Integumentary:
- ❏ None
- ❏ Eczema, Rosacea, Psoriasis, Herpes Simplex (cold sores), Herpes Zoster (shingles)

Endocrine:
- ❏ None
- ❏ Type 1 Diabetes, Type 2 Diabetes, Thyroid Dysfunction, Hormonal Dysfunction, other: _____

Hematologic / Lymphatic:
- ❏ None
- ❏ Anemia, Large-Volume Blood Loss, Ulcer, Hypercholesterolemia, other: _____

Allergic / Immune:
- ❏ None
- ❏ Drug Allergies, Environmental Allergies, Seasonal Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, other: _____

Family History - Health and Ocular

✔ or ✘ all that apply, if unknown just put a 'U'

Family Member:	**Cancer,** If yes, what type?	**Diabetes** Type 1 or Type 2?	**High Blood Pressure**	**Hyper / Hypo Thyroidism** What one:	**Cataracts** Current or Removed	**Macular Degeneration**	**Glaucoma**
Father							
Mother							
Brother							
Sister							
Son							
Daughter							

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New Patient Questionnaire

Patient Name: _____ **Date:** _____

Welcome to our office!
We have a few questions we would like you to answer for us.

1. How did you hear about InSight Eye Care?
   a. A friend or family member (Who? _____)
   b. Newspaper Ad
   c. Yellow Pages
   d. Insurance Plan Listing
   e. Facebook / Instagram
   f. Internet Search
   g. Signage outside of the office
   h. Other _____

2. What Yellow Pages do you use?
   a. Yellow Book
   b. AT&T Yellow Pages
   c. Other: _____
   d. I don't use the yellow pages

3. Who do you have for your **medical** insurance?
   a. Medical insurance plan: _____
   b. I do not have any

4. Who do you have for your **vision** insurance?
   a. Vision insurance plan: _____
   b. I do not have any

5. How long ago was your last eye exam and where? _____

6. Who is your primary care doctor or general physician? _____

Thank you for your help! ☺