

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Information

Last _____
 First _____ MI _____

Patient Medical History

CURRENT MEDICATIONS (Rx or Over the Counter)
 (List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to medications? Yes No
 If so, what medications? _____

Have you had any surgeries? Yes No

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

Have you ever been diagnosed or treated for the following health problems? Yes No

- | | | |
|-----------------------------|--------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood/Lymph | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive | <input type="checkbox"/> | <input type="checkbox"/> |
| Ears/Nose/Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema/Rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers | <input type="checkbox"/> | <input type="checkbox"/> |
| Genitourinary | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Integumentary (Skin) | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle/Bone | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychological | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus | <input type="checkbox"/> | <input type="checkbox"/> |
| Throat Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual weight losses/gains | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No

What kind? _____

Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? Yes No

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

- No
- Yes (Please check boxes)

Relationship
(Mother's or Father's side)

- Blindness
- Cataracts
- Corneal Problems
- Diabetes
- Glaucoma
- Heart Disease
- Lazy Eye
- Macular Degeneration
- Retinal Problems

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

LIFESTYLE INTERESTS

- Number of hours spent on a computer each day _____
- Are you interested in the cosmetic advantage of the thinnest, non-glare lenses available for your eyeglasses? Yes No
- Do you have proper sunglass protection? Yes No
- Do you have more than one pair of prescription glasses? Yes No
- Are you interested in contact lenses? Yes No
- Could you benefit from safety, occupational, or sporting eyewear that are eyeglasses and sunglasses? Yes No
- Are you bothered by glare or night driving? Yes No
- Do you spend a lot of time outdoors? Yes No