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Patient Name _____ Date _____

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

*******PATIENT MEDICAL HISTORY*******

Primary Care Physician _____ Date of Last Check-up _____

Current Medications (Rx and/or over the counter) Please list names of medications including eye drops, vitamins and birth control pills _____

Allergies to medications? Yes No If so, what medications? _____
Do you use cigarettes/tobacco? Yes No If so, how much? _____
Do you use alcohol? Yes No If so, how much and/or how often? _____
Have you had any surgeries? Yes No If so, what type and when? _____

Have you ever been diagnosed or treated for the following health problems?

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

*******PATIENT OCULAR HISTORY*******

Date of last eye exam _____ By Whom? _____

Do you currently wear eyeglasses? Yes No
If so, when? For distance _____ For near _____ All the time _____
Do you currently wear contact lenses? Yes No Solutions used? _____
What type of contacts? Daily Wear _____ Extended Wear _____ Replacement _____
Wearing schedule? _____ Replacement schedule? _____

Have you ever been diagnosed or treated for the following ocular problems?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions | <input type="checkbox"/> Strabismus | <input type="checkbox"/> Eye Infection |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Amblyopia |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other _____ | |

Have you ever had any ocular surgeries? Yes No
What type? When? Which eye? _____

*******FAMILY MEDICAL/OCULAR HISTORY*******

Is there a family medical history of any of the following? Yes No

	(Relationship)		(Relationship)
Blindness	<input type="checkbox"/> _____	Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____	Glaucoma	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____	Macular Degeneration	<input type="checkbox"/>

Retinal Problems	<input type="checkbox"/> _____	Diabetes	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____		

*******PATIENT LIFESTYLE*******

Do any of the following apply to you?

- Work at a computer? If so, how many hours per day? _____
- Prefer not to wear eyeglasses at times?
- Have an interest in a "test drive" of the latest contact lens designs?
- Want information on Laser Vision Correction surgery?
- Spend time outdoors? How many hours per week? _____
- Are you involved in sports? If so, what type of sports? _____
- Have family members in need of eyecare?

*******REASON FOR YOUR VISIT*******

It is our mission to provide you with the highest quality of vision care. In order to better serve you we need to have a full understanding of the reason for today's visit.

A routine vision exam always includes your prescription for eyeglasses, a functional assessment and an ocular health assessment. It does not include treatment for ocular disease and/or injury nor does it include contact lens fitting and/or evaluation. Understanding this statement, please provide (in your own words) the major purpose of today's visit:

If you are having an ocular health related problem, are you experiencing any of the following?

- | | | | |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Flash of Light-Floaters/Spots |
| <input type="checkbox"/> Grittiness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Itchiness | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Sunlight Sensitivity | <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night | |
| <input type="checkbox"/> Other _____ | | | |

Signature _____ Date _____