WELCOME TO OUR OFFICE

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

APPOINTMENT DATE: _____

NAME: _____

VERY IMPORTANT:

Who may we thank for referring you to our office? Name of friend or relative: _____

May we use your name in thanking this person? Yes ____ No ____

If not referred, how did you choose our office for your needs?

❑Another Dr._____

❑Web Page _____

❑Insurance list ❑Yellow Pages

❑Newspaper/Radio

❑Saw sign/Bldg ❑Other _____

Patient Eye History

Date of last eye exam: _____ By Whom: _____ City/ST: _____

Have you ever tried contact lenses? ☐ Yes ☐ No If yes, do you currently wear contact lenses? ☐ Yes ☐ No

If no, are you interested in trying contact lenses? ☐ Yes ☐ No

If you wear contact lenses, are you satisfied with the vision and comfort? ☐ Yes ☐ No

If you wear or have tried contacts, what kind? _____ Solutions Used _____

If interested in contacts, would you prefer Contacts that you throw away daily, bi-weekly or monthly? _____

Do you……. (Check box if your answer is yes)

❑ ..Work at a computer?
❑ ..Think you might benefit from thinner, lighter lenses?
❑ ..Spend time outdoors? (How much?) ____hrs/week
❑ ..Have prescription sunglasses?
❑ ..Prefer not to wear your glasses at times?
❑ ..Want information on Laser Vision Correction surgery?
❑ ..Have interest in a non-surgical approach to vision correction?
❑ ..Have more than 1 pair of current Rx glasses?
❑ ..Have children?
❑ ..Have family members in need of eyecare?

What type of lens do you currently wear?

❑ Single Vision ❑ Bifocal ❑ Trifocal ❑ Progressive (no line)

Have you ever been diagnosed or treated for the following?

❑ Cataracts	❑ Iritis/Uveitis
❑ Corneal Abrasion	❑ Lazy Eye
❑ Eye infection	❑ Macular Degeneration
❑ Eye injury	❑ Retinal Detachment
❑ Glaucoma	❑ Other eye disorders

Are you experiencing or have you recently experienced any of the following?

❑ Blurry vision	❑ Flash of light	❑ Light Sensitivity
❑ Burning	❑ Floater/spots	❑ Crossed eye/eye turn
❑ Tearing	❑ Grittiness	❑ Trouble seeing at night
❑ Headaches	❑ Itchiness	❑ Uncomfortable glasses
❑ Double vision	❑ Dryness	

Family Medical/Eye History (Check all that apply)

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

	Relationship
Blindness	❑ _____
Cataracts	❑ _____
Corneal Problems	❑ _____
Glaucoma	❑ _____
Lazy Eye	❑ _____
Macular Degeneration	❑ _____
Retinal Problems	❑ _____
Diabetes	❑ _____
Heart Disease	❑ _____

Patient Medical History

Current Medications (List all Rx or Over the Counter, including eye drops, vitamins, & birth control pills) _____

_____

_____

Allergies to Medications: ❑ Yes ❑ No If yes list below:

_____

Are you currently diagnosed or treated for the following?

❑ Allergies	❑ Diabetes	❑ Thyroid
❑ Asthma	❑ Heart Disease	❑ Anxiety Disorder
❑ Arthritis	❑ High Blood Pressure	❑ Acid Reflux
❑ Cancer	❑ Kidney	❑ Other
❑ Cholesterol	❑ Depression	_____