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

Patient Information

Name of family physician ______________________

Date of last physical check-up ______________________

MEDICATIONS (Rx or over-the-counter)

Allergies to medications? ❑ Yes ❑ No

If yes, what medications? ______________________

____

(List names of medications including eye drops, vitamins & birth control pills) ______________________

____

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Have you ever been diagnosed or treated for any of the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Skin Conditions	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual Weight losses/gains	❑	❑
Do you use tobacco, alcohol or other substances?	❑	❑
Currently Pregnant	❑	❑

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

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

Patient Eye History / Lifestyle Questions

What is the major purpose of this visit?

____

____

Date of last eye exam ______________________

By whom? ______________________

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

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasion
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of Light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional Dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Tearing	❑ Trouble seeing at night
❑ Uncomfortable Glasses	
❑ Other eye disorders ______________	

Have you had any surgeries? ❑ Yes ❑ No

____

____

____

Do you...(check box if your answer is yes)

❑...work at a computer? How much?____Hrs/day

❑...think you might benefit from thinner, lighter glasses?

❑...spend time outdoors? How much? __ Hrs/week

❑...have prescription sunwear?

❑...want information on Laser Vision Correction surgery?

❑...have interest in a non-surgical approach to vision correction?

❑...have family members in need of eyecare?

Do you currently wear contact lenses? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

What kind? ______________________

Are you interested in trying contact lenses? ❑ Yes ❑ No

Solutions used? ______________________

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