

# WELCOME TO OUR OFFICE

**Today's Date** \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F  
 Email Address \_\_\_\_\_  
 What is the major purpose of this visit?  
 \_\_\_\_\_  
 Any problems with your present contact lenses or glasses?  
 \_\_\_\_\_

**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 for your needs?

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

## Insurance Information

**Vision Insurance** \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

**Primary Medical Insurance** \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_

Do you participate in a flex spending account?  Yes  No  
 How will you settle your account today?  
 Cash  Check  Credit Card

## Family Medical/Eye History (Check all that apply)

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

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"/>	_____

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

## Patient Medical History

Name of Family Physician \_\_\_\_\_  
 Town \_\_\_\_\_  
 Date of Last Physical Check-up \_\_\_\_\_

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

Allergies to Medications:  Yes  No

- Have you ever been diagnosed or treated for the following?**
- Allergies
  - Diabetes
  - Thyroid
  - Asthma
  - Heart Disease
  - Other
  - Arthritis
  - High Blood Pressure
  - Cancer
  - Kidney
  - Cholesterol
  - Nerves

## Patient Eye History

Date of Last Eye Exam \_\_\_\_\_  
 By Whom? \_\_\_\_\_  
 Do you currently wear contact lenses?  Yes  No  
 What kind? \_\_\_\_\_  
 Solutions Used \_\_\_\_\_  
 Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? \_\_\_\_\_  
 Have you ever tried contact lenses?  Yes  No

- Do you..... (Check box if your answer is yes)**
- ..Work at a computer?
  - ..Think you might benefit from thinner, lighter lenses?
  - ..Have interest in a "Test Drive" of the latest contact lens designs?
  - ..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?
- If you wear bifocals, do the lines or head tilting bother you?  
 Yes  No
- If you wear contact lenses, are you satisfied with the vision and comfort?  
 Yes  No

- 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

- Do you experience or have you ever experienced?**
- Blurry vision
  - Flash of light
  - Sunlight Sensitivity
  - Burning
  - Floater/spots
  - Crossed eye/eye turn
  - Tearing
  - Grittiness
  - Trouble seeing at night
  - Headaches
  - Itchiness
  - Uncomfortable glasses
  - Double vision
  - Occasional dryness

## Social History

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor (check box)

Do you drive?	Yes	No		
If yes, do you have visual difficulty when driving?	Yes	No		
If yes, please describe: _____				
Do you use tobacco products?	Yes	No		
If yes, type/amount/how long: _____				
Do you drink alcohol?	Yes	No		
If yes, type/amount/how long: _____				
Do you take illegal drugs?	Yes	No		
If yes, type/amount/how long: _____				
Have you ever been exposed or infected with:	Gonorrhea	Hepatitis	HIV	Syphilis

## Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	NO	YES	?
<b>CONSTITUTIONAL</b>						
Fever, Weight Loss/Gain						
<b>INTEGUMENTARY (Skin)</b>						
<b>NEUROLOGICAL</b>						
Headaches						
Migraines						
Seizures						
<b>EYES</b>						
Loss of Vision						
Blurred Vision						
Distorted Vision/Halos						
Loss of Side Vision						
Double Vision						
Dryness						
Mucous Discharge						
Redness						
Sandy or Gritty Feeling						
Itching						
Burning						
Foreign Body Sensation						
Excess Watering						
Light Sensitivity						
Eye Pain or Soreness						
Chronic Infection of Eye						
Sties or Chalazion						
Flashes/Floaters in Vision						
Tired Eyes						
<b>ENDOCRINE</b>						
Thyroid/Other Glands						
<b>EARS, NOSE, MOUTH</b>						
Allergies/Hay Fever						
Sinus Congestion						
Runny Nose						
Post-Nasal Drip						
Chronic Cough						
Dry Throat/Mouth						
<b>RESPIRATORY</b>						
Asthma						
Chronic Bronchitis						
Emphysema						
<b>VASCULAR</b>						
Diabetes						
Heart Pain						
High Blood Pressure						
Vascular Disease						
<b>GASTROINTESTINAL</b>						
Diarrhea						
Constipation						
<b>GENITOURINARY</b>						
Kidney/Bladder						
<b>BONES / JOINTS / MUSCLES</b>						
Rheumatoid Arthritis						
Muscle Pain						
Joint Pain						
<b>LYMPHATIC / HEMATOLOGIC</b>						
Anemia						
Bleeding Problems						
<b>IMMUNOLOGIC</b>						
<b>PSYCHIATRIC</b>						

If you have answered YES to any of the above or have a condition not listed, please explain and list medications:

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