Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date:

Patient Information

Last: ______________________________
First: ________________ MI: ___________
Street: ____________________________
City: __________________ State: _______
Zip Code: __________________________
Home Phone: ________________________
Work Phone: ________________________
Cell Phone: _________________________
Email Address:
____

Are you OK with text reminders? ☐ Yes ☐ No
If not, please indicate how you would like to be contacted: ________________

Date of Birth: ________________ Age: _________
Sex: M F
SSN: ________________
Employer (or School): ________________
Occupation (or Grade): ________________
Spouse (or Parent's Name): ________________
Spouse (or Parent's Work): ________________

If not referred, how did you choose our office?
☐ Friend or Relative
- Who can we thank?________________

☐ Another Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Google
☐ Other:
____

Insurance Information

Vision Insurance:________________________
Subscriber Name:________________________
Subscriber SSN or ID#:____________________
Subscriber Birth Date:____________________

Primary Medical Insurance:________________
Subscriber Name:________________________
Member ID #:___________________________
Subscriber Birth Date:____________________

Secondary Medical Insurance:______________
Subscriber Name:________________________
Subscriber SSN/ID#:______________________
Subscriber Birth Date:____________________

Do you participate in an HSA or flex spending account?
☐ Yes ☐ No

Do you...(check all that apply):

☐ ...use digital devices on a regular basis? If yes, approx. how many hours per day? _______hrs/day
☐ ...think you might benefit from thinner, lighter lenses?
☐ ...prefer NOT to wear glasses at times?
☐ ...spend time outdoors? How often? Approx. ____hrs/week
☐ ...participate in sports/activities or have any hobbies? If yes, please specify:
____
____
____

Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Name: ______________________________

Date: ______________________________________

Patient Eye History

Main reason for today's visit:

____

____

Approximate Date of Last Eye Exam: _______________

By Whom? _____________________________________

Do you currently or have you ever worn glasses?
☐ Yes ☐ No

Do you currently or have you ever worn contact lenses?
☐ Yes ☐ No

Have you had any eye-related surgeries of any kind?
☐ Yes ☐ No

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

☐ Cataracts	☐ Blurred Distance Vision
☐ Macular degeneration	☐ Blurred Near Vision
☐ Glaucoma	☐ Eye strain
☐ Diabetic Retinopathy	☐ Eye pain
☐ Dry Eye	☐ Severe light sensitivity
☐ Eye infection	☐ Headaches
☐ Flashes/floaters	☐ Poor night vision
☐ Iritis/Uveitis	☐ Glare
☐ Retinal detachment	☐ Double Vision
☐ Lazy Eye	☐ Total loss of vision
☐ Red eyes	☐ Burning/grittiness
☐ Contact lens problems	☐ Itchiness
☐ Uncomfortable glasses	☐ Tearing/Watering

☐ Other eye disorders: ______________________________

Family Medical/Eye History

Do you have a family medical history of any of the following? (check all that apply and indicate mother or father's side):

		Relationship
Blindness	☐	________________
Cataracts	☐	________________
Corneal Problems	☐	________________
Glaucoma	☐	________________
Diabetes	☐	________________
Heart Disease	☐	________________
Macular Degeneration	☐	________________
Retinal Problems	☐	________________
High Blood Pressure	☐	________________
Cancer	☐	________________
Thyroid Disease	☐	________________

☐ No to all

Continued on next page...

Patient Medical History Form, Continued

Patient Medical History

Name of Family Physician:

____

Address: ______________________________

Date of Last Physical Check-Up: ________________

Height:____________Weight:______________

Are you currently pregnant? □ Yes □ No

Current Medications (Rx AND Over-The-Counter)
(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency if known. We can make a copy of a list if you have one!)

____

____

____

____

____

Allergies to medications or substances?□ Yes□ No

If so, what medications/substances? ________________

____

Do you consume alcohol? □ Yes □ No

Do you use cigarettes/tobacco? □ Yes□ No

Other substances? If so, please list _______________

Patient Medical History, Cont.

Have you ever been diagnosed or treated for the following health problems? (please list condition if not specified)

	Yes		No
Allergies	□		□
Arthritis	□		□
Blood/Lymph	□	__________	□
Bronchitis	□		□
Cancer	□	__________	□
High Cholesterol	□		□
Depression	□		□
Diabetes	□		□
Digestive	□	__________	□
Skin conditions	□	__________	□
Fatigue	□		□
Genitourinary problems	□	__________	□
High Blood Pressure	□		□
Kidney disease	□	__________	□
Migraines	□		□
Multiple Sclerosis	□		□
Other Psychological	□	__________	□
Respiratory problems	□	__________	□
Sinus	□		□
Sleep Apnea	□		□
Strokes	□		□
Thyroid	□		□
Unusual weight losses/gains	□		□

Other conditions: ____________________________