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: _______________

Cell Phone: ______________________ Home Phone: ______________________ Work Phone: ____________________

Sex: ☐ Male ☐Female Date of Birth: ______________ Age: __________ SSN: _______________________________

Email Address:____

Employer/School: _________________________ Occupation/Grade: ________________________

Spouse/Parent's Name: ____________________ Spouse/Parent's Employer: ____________________

Medical Insurance:

☐ Blue Cross Blue Shield ☐ United Healthcare ☐ Cigna ☐ Aetna

☐ Medicare ☐ Medicaid ☐ MediShare ☐ Other: ____________________________

Vision Insurance:

☐ VSP ☐ Superior ☐ Spectera ☐ Davis ☐ Eyemed ☐ Other: ____________________________

Subscriber Name: _______________________________

Subscriber Birth Date: ____________________________

Do you participate in a flex spending account? ☐Yes ☐No

How did you first hear about our office?

☐ Friend or Relative. Whom may we thank for the referral? ________________________________

☐ Another Doctor

☐ Insurance List

☐ Saw Sign/Building

☐ Facebook

☐ Online Search

☐ Instagram

☐ Neighborhood webpage

☐ Other: __________________________________

Do you… (check all that apply):

☐…use digital devices on a regular basis?

If yes, 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?

If yes, how often? ____hrs/week

☐…participate in sports or other activities?

If yes, please specify: _____________________________

____

Medical History

Name of Family Physician: ___________________________________ City: ____

Date of Last Physical Check-Up: _____________________ Height: _________________Weight: __________________

Do you use:

Cigarettes/Tobacco? ☐ Yes ☐ No

Alcohol? ☐ Yes ☐ No

Other substances? ☐ Yes ☐ No

Females:

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

If so, what medications? ____

Current Medications (Rx or Over-The-Counter)

List name of medications including eye drops, vitamins, & birth control pills: dosages and frequency.

____

____

Non-eye related surgeries or hospitalizations:

____

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

☐ Cancer	☐ Heart Disease	☐ Osteoporosis
☐ Developmental Disability	☐ Congestive Heart Failure	☐ Gout
☐ Hearing Loss	☐ Vascular Disease	☐ Allergies
☐ Chronic Sinusitis	☐ Asthma	☐ Eczema
☐ Dry Mouth	☐ Chronic Bronchitis	☐ Rosacea
☐ Multiple Sclerosis	☐ Emphysema	☐ Psoriasis
☐ Epilepsy	☐ Sleep Apnea	☐ Cold Sores
☐ Cerebral Palsy	☐ Crohn's	☐ Shingles
☐ Stroke/CVA	☐ Colitis	☐ Type 1 Diabetes
☐ Migraine	☐ Celiac Disease	☐ Type 2 Diabetes
☐ Autism Spectrum Disorder	☐ Kidney Disease	☐ Thyroid Dysfunction
☐ ADD/ADHD	☐ STD	☐ Hormonal Dysfunction
☐ Depression	☐ Arthritis	☐ Anemia
☐ Anxiety	☐ Fibromyalgia	☐ High Cholesterol
☐ Bipolar Disorder	☐ Muscular Dystrophy	☐ Lupus
☐ High Blood Pressure	☐ Ankylosing Spondylitis	☐ Sjogren's Syndrome

Eye History

Date of Last Eye Exam? ____________________________ By Whom? _______________________________________

Have you had any eye-related surgeries of any kind?

☐ Yes ☐ No List: ____

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

☐ Blurry Vision	☐ Burning	☐ Cataracts	☐ Corneal Abrasions
☐ Crossed Eyes/Eye Turn	☐ Double Vision	☐ Eye Infections	☐ Eye Injury
☐ Flashes of Light	☐ Floaters/Spots	☐ Glaucoma	☐ Grittiness
☐ Headaches	☐ Iritis/Uveitis	☐ Itchiness	☐ Lazy Eye (Amblyopia)
☐ Macular Degeneration	☐ Dry Eyes	☐ Retinal Detachment	☐ Sunlight Sensitivity
☐ Trouble Seeing at Night	☐ Tearing	☐ Red, Puffy, or Scaly Eyelids	
☐ Other ___________________			

Family Medical/Eye History

Do you have a family medical history of any of the following? ☐ Adopted

		Relationship
Blindness	☐ Mom's Side ☐ Dad's Side	____
Cataracts	☐ Mom's Side ☐ Dad's Side	____
Corneal Problems	☐ Mom's Side ☐ Dad's Side	____
Retinal Problems	☐ Mom's Side ☐ Dad's Side	____
Glaucoma	☐ Mom's Side ☐ Dad's Side	____
Lazy/Crossed Eyes	☐ Mom's Side ☐ Dad's Side	____
Macular Degeneration	☐ Mom's Side ☐ Dad's Side	____
Diabetes	☐ Mom's Side ☐ Dad's Side	____
Heart Disease	☐ Mom's Side ☐ Dad's Side	____
Cancer	☐ Mom's Side ☐ Dad's Side	____