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

Patient Medical History

Date: _____
Patient Name: _____
Date of Birth: _____
Primary Care Physician:_____
Other Physician:_____

Patient Eye History

Date of Last Eye Exam_____

Have you ever tried contact lenses? □ Yes □ No

Do you currently wear contact lenses? □ Yes □ No
What kind?_____
Solutions used?_____

Do you wear glasses? □ Yes □ No

List any eye surgeries_____

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

□ Macular Degeneration □ Floaters/Spots/Flashes
□ Cataracts □ Dry Eyes
□ Glaucoma □ Blurry Vision
□ Color Blindness

Family Medical/Eye History (Check all that apply)

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

	Relationship		Relationship
Blindness □	_____	Corneal Problems □	_____
Cataracts □	_____	Eye Surgery □	_____
Lazy Eye □	_____	Crossed Eyes □	_____
Glaucoma □	_____	Retinal Problems □	_____
Macular Degeneration □	_____		

Cancer □ _____
Diabetes □ _____
Heart Disease □ _____

Please List ALL Your Medications:
(Prescription, Over-the-Counter, Vitamins, Supplements, Oxygen, C-Pap, Bi-Pap and Eye Drops)
If more space is needed, please give copy of your list to the technician

_____
_____
_____
_____
_____
_____

Pharmacy _____ City _____

Are you allergic to any medications? □ No □ Yes
Please list: _____

_____

Have you had any surgeries in the past 10 years? □ Yes □ No
Please List:

_____

Do you use: Cigarettes/Tobacco □ Yes □ No
Alcohol □ Yes □ No
Former users please list quitting date: _____
Are you pregnant or nursing? □ Yes □ No
Recent Weight Loss □ Yes □ No

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

Allergy/ENT
Seasonal Allergies □ Yes □ No Hearing Impaired □ Yes □ No
Sinus Problems □ Yes □ No

Cardiovascular
High Cholesterol □ Yes □ No Stroke □ Yes □ No
High Blood Pressure □ Yes □ No Heart Attack □ Yes □ No

Endocrine
Thyroid Disorders □ Yes □ No Diabetes □ Yes □ No
Crohn's Disease □ Yes □ No Last A1C_____
LastBlood Sugar_____

Gastrointestinal
Gallstones □ Yes □ No Hepatitis □ Yes □ No
Ulcers □ Yes □ No Acid Reflux □ Yes □ No

Genitourinary
Kidney Stones □ Yes □ No Menopause □ Yes □ No
Prostate □ Yes □ No

Hematologic/Lymphatic
Bleeding Disorders □ Yes □ No Anemia □ Yes □ No
Breast Cancer □ Yes □ No

Integumentary
Lupus □ Yes □ No

Immunologic
Shingles □ Yes □ No Year_____ HIV/AIDS □ Yes □ No
Lyme Disease □ Yes □ No

Musculoskeletal
Down Syndrome □ Yes □ No Arthritis □ Yes □ No
Rheumatoid Arthritis □ Yes □ No Osteoporosis □ Yes □ No

Neurologic
Migraines □ Yes □ No Seizure □ Yes □ No
MS □ Yes □ No Vertigo □ Yes □ No
Fibromyalgia □ Yes □ No Autism □ Yes □ No

Psychiatric
Anxiety □ Yes □ No Depression □ Yes □ No
ADHD □ Yes □ No ADD □ Yes □ No

Respiratory
Asthma □ Yes □ No Emphysema □ Yes □ No
Sleep Apnea □ Yes □ No COPD □ Yes □ No

Please list any other medical conditions:

_____
_____