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

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
Sinus Problems □ Yes □ No
Hearing Impaired □ Yes □ No

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

Endocrine
Thyroid Disorders □ Yes □ No
Crohn's Disease □ Yes □ No
Diabetes □ Yes □ No
Last A1C ______
Last Blood Sugar ______

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

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

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

Integumentary
Lupus □ Yes □ No

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

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

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

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

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

Please list any other medical conditions:

____
____