CYPRESS VISION THERAPY

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: _____

Email Address:_____

Patient's SSN: _____

Date of Birth: _____Age: _____

Sex: M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

Spouse (or Parent's Work): _____

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: _____

Insurance Information

Medical Insurance: _____

Member ID #: _____

Subscriber Name: _____

Subscriber Birth Date: _____

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

Lifestyle Questions

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? How often? ____hrs/week
☐…participate insports or other activities?

If yes, please specify: _____
_____
_____

Patient Eye History

Date of Last Eye Exam? _____

By Whom? _____

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

☐ Yes ☐ No

List: _____

Patient Eye History, Continued

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

☐Blurry Vision ☐Burning

☐Cataracts ☐ Corneal Abrasions

☐Crossed eye/Eye turn ☐Double Vision

☐Eye Infections ☐ Eye Injury

☐Flash of light ☐Floaters/Spots

☐Glaucoma ☐Grittiness

☐ Headaches ☐ Iritis/Uveitis

☐Itchiness ☐Lazy Eye (Amblyopia)

☐Macular Degeneration ☐Dry Eyes

☐Retinal Detachment ☐Sunlight Sensitivity

☐Tearing ☐ Trouble seeing at night

☐ Red, puffy, or scaly eyelids

☐Other eye disorders: _____

Patient 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 or 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.

_____

_____

_____

_____

Patient Medical History, Continued

List any non-eye related surgeries or hospitalizations:

_____

_____

_____

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

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Cholesterol	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes/Rosacea	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
Blood/Lymph	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Chronic Asthma	☐	☐
Thyroid (hyper/hypo)	☐	☐
Unusual weight losses/gains	☐	☐

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	☐	_____
Retinal Problems	☐	_____
Glaucoma	☐	_____
Lazy or Crossed Eyes	☐	_____
Macular Degeneration	☐	_____
Diabetes	☐	_____
Heart Disease	☐	_____
Cancer	☐	_____