Providing the Best Possible Eyecare

PATIENT INFORMATION

The information in this confidential case history form is critical to the evaluation of your vision and health. Thank you for completing!

Today's Date__________________

Last Name ____ First Name ____________________________________ MI__________

Email Address _____________________________________ Date of Birth ____________________ Age _______________________

Address____City___________________________ State________Zip________________

Work (____)____________________________________Cell (____)_________________________ Home (____)________________

Preferred method of communication: _____Home Phone _____Cell Phone _____ Email _____Mail

Employer (or School)________________________________Occupation (or Grade) _______________________________________

Spouse (or Parent) Name ____________________________Spouse (or Parent) Occupation___________________________________

Emergency Contact/Relationship____Phone:________________________

Race or Ethnic Background: ____Caucasian ____American /Alaskan Native ____Asian America ___African American ____Hispanic /Latino ____Hawaiian/Pacific Islander ____ Other (specify)____

What is the major purpose of this visit? ____

____

Any problems with your present contact lenses or glasses? ____

INSURANCE INFORMATION

Vision Insurance___________________________________ **Primary Medical Insurance**__________________________________

Subscriber Name____________________________________ Subscriber Name____

Subscriber ID Number________________________________ Subscriber ID Number _______________________________________

Subscriber Date of Birth______________________________ Subscriber Date of Birth ____________________________________

Subscriber Employer _________________________________ Subscriber Employer____

Are/Do you:	Y/N		Y/N		Y/N		Y/N
Currently wear glasses?		Satisfied with your glasses?		Wear Multifocal lenses?		Satisfied with them?	
Ever tried contacts?		Currently using contacts?		Hours worn per day?		Satisfied with your contacts?	
Brand & Type: (Daily, monthly, etc.)				Solution used:			
Want information on LASIK?		Have Prescription Sunglasses?		More that one pair of glasses?		Play sports with eyewear?	
Have family members who need eyecare?		Interested in thinner, lighter lenses?		Work at a computer?		Hours per day?	
Spend time outdoors?		Hours per week?		Any questions about your eyes or vision?			

Who may we thank for referring you to our office?

Name of friend or relative _______________________________ If not referred, how did you choose our office for your needs?

____Another Doctor _____Insurance List _____Saw sign or building _____Newspaper _____Radio _______TV

____Yellow Pages: Which directory_________________________ Internet Search _____Webpage _____Other___________________

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Name (print)____ Age_________ DOB____________

EYE HISTORY

Date of your last eye exam____________ By Dr. /Clinic_________________________ Phone number ___________________________

PATIENT MEDICAL HISTORY

Name of Family Physician____ Phone_____________________________________

Date of Last Physical Exam _________________ Height_________ Weight________ Allergies to Medications _____Yes ____No

If yes please list: ____

Drink Alcohol? Y N How many drinks per week? ___________ Smoke Y N # per day ______

Current Medications and Dosage (Rx or Over the Counter)

List name of medications, including eye drops, vitamins, and birth control pills, and herbal supplements:

____

____

Have you or any of your family ever had or been treated for any of the following? (*check all the apply)*

	You ✔	Family ✔		You ✔	Family ✔
HIV/AIDS			High Cholesterol		
Allergies			Iritis / Uveitis		
Arthritis			Kidney Disease		
Asthma			LASIK or PRK		
Blood/Lymph Disorder			Lazy Eye		
Cancer			Lupus		
Cataracts			Macular Degeneration		
Crossed Eye			Neurological Conditions/MS		
Diabetes			Psychiatric Disorder		
Ear, Nose, Throat Conditions			Retinal Detachment		
Glaucoma			Seizures		
Gastrointestinal Disorders			Skin Conditions		
Heart Disease			Stroke		
High Blood Pressure			Thyroid Dysfunction		

Have you or any of your family ever had or been treated for any of the following? (*check all the apply)*

	✔		✔		✔
Blurry Vision		Excessive Tearing/watering?		Headaches	
Burning		Eye Pain/Soreness?		Itching	
Corneal Abrasion		Eye Infection?		Light Flashes	
Discharge		Eye Injury		Light/sun sensitivity	
Double Vision		Floaters or spots		Redness	
Dryness		Halos		Sandy or gritty feeling	
Visual problems while driving at night?		Visual problems driving during the day?		Eye fatigue with computer use	

Signature ____ Date_______________________

Has our staff reviewed this form with you and answered any questions you have? _______Yes No_______