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

Patient Eye History

Patient Name: _____ **DOB:**_____

Date: _____

Reason for Today's Visit _____

Date of Last Eye Exam _____

By Whom? _____

Are you currently using eye drops? ***yes*** ***no***

If yes, please list _____

Do you currently wear glasses? ***yes*** ***no***

Do you currently wear contact lenses? ***yes*** ***no***

Brand of contact lenses _____

Brand of contact lens solution _____

Have you worn contact lenses in the past? ***yes*** ***no***

Are there any problems with your current glasses or contact lenses?

yes ***no***

If yes, please list _____

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

- □ Blurry Vision
- □ Double Vision
- □ Light Flashes
- □ Eye Infections
- □ Floaters or Spots
- □ Dry eye
- □ Light Sensitivity
- □ Eye Pain or Soreness

Patient/Family Eye History (circle all that apply)

Blindness	*yes*	*no*	*family*
Cataracts	*yes*	*no*	*family*
Corneal Problems	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Medications

Please list **ALL** your medications and dosage including prescription & over-the-counter medication, vitamins, and supplements. If more space is needed, please give copy of your list to the technician.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy _____ City _____

Do you have any medication or non-medication allergies?

yes *no*

Please list: _____

_____

Patient/Family Medical History

Have you had any surgeries in the past 10 years? *yes* *no*

*Please list:*_____

_____

Do you smoke or use tobacco? *yes* *no*

Have you ever smoked or used tobacco? yes *no*

*Former users please list quitting date:*_____

Do you use alcohol? yes *no*

Are you pregnant or nursing? yes *no*

Have you or a family member experienced, or been treated for any of the following? Circle all that apply.

Allergy			
Seasonal Allergies	*yes*	*no*	*family*
Sinus Problems	*yes*	*no*	*family*
Ear, Nose, Throat Conditions	*yes*	*no*	*family*
Cardiovascular			
High Cholesterol	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Heart Attack	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
Endocrine			
Diabetes	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*
Gastrointestinal			
Gall Stones	*yes*	*no*	*family*
Peptic Ulcers	*yes*	*no*	*family*
Hepatitis	*yes*	*no*	*family*
Acid Reflux	*yes*	*no*	*family*
Genitourinary			
Kidney Stones	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Hematologic/Lymphatic			
Blood/Lymph Disorder	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Anemia	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Immunologic			
Shingles	*yes*	*no*	*family*
AIDS/HIV	*yes*	*no*	*family*
Musculoskeletal			
Arthritis	*yes*	*no*	*family*
Osteoporosis	*yes*	*no*	*family*
Neurologic			
Migraines	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Other Neurological Conditions	*yes*	*no*	*family*
Psychiatric			
Anxiety	*yes*	*no*	*family*
Depression	*yes*	*no*	*family*
Other Psychiatric Disorders	*yes*	*no*	*family*
Respiratory			
Asthma	*yes*	*no*	*family*
Emphysema	*yes*	*no*	*family*

Please list any other medical conditions: