



WELCOME BACK TO OUR OFFICE

Today's Date _____
Last _____ First _____ Mi _____
Street _____
City _____ State _____ Zip Code _____
Home Phone _____
Work Phone _____
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) _____
Email Address _____
What is the major purpose of this visit?

Any problems with your present contact lenses or glasses?

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a flex spending account? Yes No

How will you settle your account today?
 Cash Check Credit Card

Family Medical/Eye History (Check all that apply)

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

	Relationship
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____

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

Patient Medical History

Name of Family Physician _____
Town _____
Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to Medications Yes No

Have you ever been diagnosed or treated for the following?

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney	_____
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Nerves	_____

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____
Do you currently wear contact lenses? Yes No
What kind? _____
Solutions Used _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eye? _____
Have you ever tried contact lenses? Yes No

Do you.....(check box if your answer is yes)

- ..Work at a computer?
- ..Think you might benefit from thinner, lighter lenses?
- ..Have interest in a "Test Drive" of the latest contact lens designs?
- ..Spend time outdoors? (How much?) _____ hrs/week
- ..Have prescription sunglasses?
- ..Prefer not to wear your glasses at times?
- ..Want information on Laser Vision Correction surgery?
- ..Have interest in a non-surgical approach to vision correction?
- ..Have more than 1 pair of current Rx glasses?
- ..Have children?
- ..Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you?
 Yes No

If you wear contact lenses, are you satisfied with the vision and comfort?
 Yes No

Have you ever been diagnosed or treated for the following

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Eye infection	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Eye injury	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other eye disorders

Do you experience or have you ever experienced?

<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Flash of light	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Burning	<input type="checkbox"/> Floater/spots	<input type="checkbox"/> Crossed eye/eye turn
<input type="checkbox"/> Tearing	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Headaches	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Uncomfortable
<input type="checkbox"/> Double vision	<input type="checkbox"/> Occasional dryness	