WELCOME TO OUR OFFICE: The information in this confidential case history form is critical for the evaluation of your vision and health.

Today's Date:_______________

Patient Information:

Last_________________________ First_________________________ MI__________

DOB_____________ Age: ________ Sex: M F SSN_________________

Address__________________ City__________________ State______ _Zip__________

Cell Ph#______________ Home Ph#______________ E-mail__________________

Employer/School_____________________ Occupation/Grade____________________

Spouse (Or Parent's Name)______________

Insurance Information

Vision Insurance________________	Medical Insurance________________
Subscriber Name________________	Subscriber Name________________
Subscriber ID________________	Subscriber ID________________
Subscriber DOB________________	Subscriber DOB________________

Very Important! New Patients Only: Who may we thank for referring you to our office?
Name of friend or relative ______________________
If not referred, how did you choose our office?

__Another Dr. (Name of Dr.______________) __Insurance List __Saw sign /building __Online Directory

___Google Search __Yelp __Angie's List __Yahoo ___Other________________

Patient Medical History

Name of family Physician ______________________ Last Physical Exam ______________
Have you ever been diagnosed or treated for the following health problems? Circle all that apply

- **Constitutional**
  Cancer
  Fatigue
  Developmental Issues
- **Ears/Nose/Throat**
  Hearing Loss
  Sinus
  Dry Mouth
- **Neurological**
  Multiple Sclerosis
  Epilepsy
  Stroke
  Migraine
- **Psychological**
  Depression
  ADD/ADHD
  Anxiety
  Bipolar Disorder
- **Cardiovascular**
  High blood pressure
  Heart disease
  Vascular disorder
- **Respiratory**
  Asthma
  Sleep Apnea
  Bronchitis
  Emphysema
  COPD
- **Gastrointestinal**
  Chron's
  Ulcers
  Colitis
  Acid Reflux
  Celiac
- **Genitourinary**
  Kidney Issues
  Prostate
  STD
  Herpes
  Pregnant
- **Muscle-skeletal**
  Osteoarthritis
  Fibromyalgia
  Other__________
- **Skin**
  Rosacea
  Psoriasis
  Cold sores
  Shingles
- **Endocrine**
  Type I Diabetes
  Type II Diabetes
  Thyroid
  Hormone Dysf.
- **Blood/Lymph**
  High Cholesterol
  Anemia
  Blood Loss
- **Allergy/Immune**
  Rheum. Arthritis
  Lupus
  Sjogren's Syndr.

Current Medications: (Including vitamins and OTC)

____

____

____

____

Medication Allergies

____

____

Other Allergies

____

Ocular History:

Have you ever experienced, been diagnosed or treated for any of the following? **Circle all that apply**

- Blurry Vision
- Itching
- Tearing
- Burning
- Grittiness
- Double Vision
- Dryness
- Other________________
- Sensitive to sun
- Poor Night vision
- Eye Injury
- Flashes of Light
- Headaches
- Floaters/Spots
- Poor fitting glasses
- Eye Surgery
- Cataracts
- Lazy Eye
- Iritis/uveitis
- Corneal Abrasion
- Corneal Ulcer
- Glaucoma
- Macular Degeneration
- Glaucoma

Date of last eye exam________________________ **By Whom?** ________________________

Social History:

Drinking: Y N Amount________________ Smoking Y N Amount ____________________

Circle the one that applies: Never Smoked Current Smoker Former Smoker

Family History Circle the ones that apply and tell us what family member is/was affected

- Diabetes Type I II ____________________
- High Blood Presure ____________________
- Heart Disease ____________________
- Cancer ____________________
- Thyroid ____________________
- Blindness ____________________
- Cataract ____________________
- Macular Degeneration ____________________
- Glaucoma ____________________
- Lazy Eye ____________________
- Retinal Detachment ____________________

Contact Lens History:

Do you currently wear contact lenses? Y N What kind? ____________________________

How often do you replace your contact lenses? ________________ How old is your current pair? ________________

What Solution do you use to clean and store your lenses? ____________________________

Reason for today's visit: ____

X______________________________ ________________________

Signature (Parent or guardian signature) **Date**