

# WELCOME BACK TO OUR OFFICE

**Today's Date** \_\_\_\_\_  
 Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F  
 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?**

Blindness	<input type="checkbox"/>	_____	Relationship
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 eyes? \_\_\_\_\_

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 design?
- ..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"/> Burning       | <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 glasses   |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Double vision | <input type="checkbox"/> Occasional dryness      |