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

Patient Medical History

Name of Family Physician_____
Phone _____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
If so, what medications? _____
_____

Have you had any surgeries? ☐ Yes ☐ No
Any eye surgeries? ☐ Yes ☐ No

Do you use cigarettes, tobacco, alcohol, or other substances? ☐ Yes ☐ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers (Chronic)	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐

Patient Eye History

Date of last Eye Exam_____
By Whom? _____

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No
What kind _____
Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? ☐ Yes ☐ No

Do you prefer clear or colored contact lens?
☐ Clear ☐ Colored

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

Family Med/Eye History (Check all that apply)

Is there a family medical history of any of the following: ☐ No ☐ Yes (please check boxes)

		Relationship (ex. Mom, Dad, Aunt, Uncle, Grandmother, Grandfather, Brother, Sister)
Blindness	☐	_____
Cataracts	☐	_____
Corneal Problems	☐	_____
Diabetes	☐	_____
Glaucoma	☐	_____
High Blood Pressure	☐	_____
Lazy Eye	☐	_____
Macular Degeneration	☐	_____
Retinal Problems	☐	_____

EYE CONTACT