

Case History

Last Name First Name MI Exam Date
DOB / / Age Gender M F Vision Insurance Health Insurance
When was your last eye exam?
What is the reason for your visit?

Do you feel your eyes are changing? Y/N
Do you have questions about other eye issues? Y/N
Do you have dry eyes or allergies? Y/N If yes, please explain:

PAST HISTORY

Have you had any surgeries? Y/N
Are you taking any medications? Y/N If yes, please explain:

Are you allergic to any medications? Y/N If yes, please explain:

SOCIAL HISTORY

Occupation / School Grade
Does your occupation / hobby require special use of your eyes? Y/N If yes, please explain:
How often do you use a computer?

FAMILY HISTORY

Has anyone in your family ever been diagnosed with:
Cataracts Macular Degeneration Turned Eyes Diabetes High Blood Pressure Glaucoma Other

PATIENT HISTORY

Have you ever been diagnosed with:
Cataracts Macular Degeneration Turned Eyes Diabetes High Blood Pressure Glaucoma Other

Other eye related problems:

Constitutional None
development disability
weight loss
fever
fatigue
trauma

Ears, Nose, Mouth, & Throat None
upper respiratory tract infection

Cardiovascular None
vascular disease
stroke
heart disease
high blood pressure

Respiratory None
cigarette smoker
emphysema
bronchitis
asthma

Gastrointestinal None
Crohn's
colitis
ulcer
digestive

Genitourinary None
urinary tract infections
kidney ailments
STD - viral herpetic, chlamydia

Musculoskeletal None
ankylosing spondylitis
osteoarthritis
muscular dystrophy
fibromyalgia

Hematological None
large volume blood loss
leukemia

Immunologic None
rheumatoid arthritis
lupus

Integumentary None
eczema
rosacea
psoriasis

Neurological None
multiple sclerosis
epilepsy

Psychiatric None
depression
panic disorder
schizophrenia

Endocrine None
non-insulin dependent diabetes
insulin dependent diabetes
thyroid dysfunction
hormonal dysfunction
other

CONTACT LENSES

If you DO NOT wear contacts:
I have never worn contacts
I am not interested in contacts
I would like to know my options

If you DO wear contacts:
Daily Wear
Extended Wear
Soft
Gas Permeable
Hard

Monovision
Bifocal
Astigmatism or Toric
Disposable

What brand of solution do you use?
Optifree
Renu
Complete
Clearcare
Boston

At present, how long have your contacts been on your eyes? hours days
What is the maximum time you wear your contacts? hours days
Please list any contact lens complaints:

Doctor's initials