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

Primary Care Physician _____ Phone/FAX Number _____ Date of Last Exam _____

Current Medication List: _____

_____

Allergies to Medication? ☐ Yes ☐ No If so, what meds? _____

Do you use cigarettes/tobacco? ☐ Yes ☐ No If so, how many packs per day? _____ # of Years? _____

Do you use alcohol? ☐ Yes ☐ No ☐ Socially ☐ Daily #

Do you use illegal drugs? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No Are you Right or Left handed? ☐ Right Handed ☐ Left Handed

Have you had any surgeries? ☐ Yes ☐ No **Please list:** _____

_____

Hobbies: _____

Reason for Today's Visit: _____

Eye History

Date of Last Eye Exam: _____

Where? _____

EYEWEAR HISTORY

Have you tried contact lenses? ☐ Yes ☐ No

Do you wear contacts lenses? ☐ Yes ☐ No

Do you sleep in your contacts? ☐ Yes ☐ No

Are your contacts comfortable? ☐ Yes ☐ No

Do you have glasses? ☐ Yes ☐ No

Do you have sunglasses? ☐ Yes ☐ No

Are you planning to have contact lens evaluation & management today?* ☐ **Yes** ☐ **No**

Additional fees usually apply even with a vision plan, $64 to $375, depending on the complexity

COMPUTER HISTORY

How many hours are you on a computer? _____

Headaches?	☐ Mild	☐ Moderate	☐ Severe
Burning Eyes?	☐ Mild	☐ Moderate	☐ Severe
Dry, tired or sore eyes?	☐ Mild	☐ Moderate	☐ Severe
Squinting at computer?	☐ Mild	☐ Moderate	☐ Severe
Double vision?	☐ Mild	☐ Moderate	☐ Severe
Distance is blurry after computer use?	☐ Mild	☐ Moderate	☐ Severe
Overall body fatigue or tiredness?	☐ Mild	☐ Moderate	☐ Severe
Neck, shoulder or back pain?	☐ Mild	☐ Moderate	☐ Severe
Driving/Night vision is worse after computer use?	☐ Mild	☐ Moderate	☐ Severe

Medical History	*Personal*	*Family Member(s)*
OCULAR HISTORY		
Macular Degeneration	☐ **Yes** ☐ **No**	☐ _____
Retinal Detachment	☐ Yes ☐ No	☐ _____
Glaucoma	☐ **Yes** ☐ **No**	☐ _____
Cataracts	☐ Yes ☐ No	☐ _____
Medical History		
Allergies	☐ Yes ☐ No	☐ _____
Blood/Lymph Nodes	☐ Yes ☐ No	☐ _____
Cancer	☐ Yes ☐ No	☐ _____
Cholesterol	☐ **Yes** ☐ **No**	☐ _____
Chronic Bronchitis	☐ Yes ☐ No	☐ _____
Diabetes	☐ **Yes** ☐ **No**	☐ _____
Digestive	☐ Yes ☐ No	☐ _____
Ear/Nose/Throat	☐ Yes ☐ No	☐ _____
Endocrine	☐ Yes ☐ No	☐ _____
Fatigue	☐ Yes ☐ No	☐ _____
Fever	☐ Yes ☐ No	☐ _____
Genitourinary	☐ Yes ☐ No	☐ _____
High Blood Pressure	☐ **Yes** ☐ **No**	☐ _____
Kidney	☐ Yes ☐ No	☐ _____
Muscle/Bone	☐ Yes ☐ No	☐ _____
Neurological	☐ Yes ☐ No	☐ _____
Psoriasis/Eczema/Rashes	☐ Yes ☐ No	☐ _____
Psychological	☐ Yes ☐ No	☐ _____
Respiratory	☐ Yes ☐ No	☐ _____
Rheumatoid Arthritis	☐ **Yes** ☐ **No**	☐ _____
Lupus	☐ **Yes** ☐ **No**	☐ _____
Sinus	☐ Yes ☐ No	☐ _____
Throat Infections	☐ Yes ☐ No	☐ _____
Thyroid	☐ **Yes** ☐ **No**	☐ _____
Unusual Weight Loss/Gain	☐ Yes ☐ No	☐ _____