CASE HISTORY FORM

Name_____ Age_____ Birthdate_____/_____/_____ Current Date_____

Address_____ City_____ Zip Code_____

Home Phone_____ Work Phone_____ Email_____

SS#_____Occupation_____Hobbies_____

Payment By: Cash_____ Check_____ Credit Card _____ Ins_____ Medical_____ Medi-Care_____

Main Vision Problems?_____

Glasses Worn Before? Yes No If yes, were glasses worn: Fulltime Far only Near only
Last Eye Exam? Never Over 5 years 3-5 years 2-3 years Under 2 years

Please list ALL MEDICATIONS you are CURRENTLY TAKING:

Please list ALL FOOD and MEDICATIONS you are ALLERGIC TO:

Are you interested in Contact Lenses? YES____ NO_____

Do you have any of these vision problems?	**Yes**	**No**	**If Yes, how often and since when?**
Unclear vision far away	____	____	_____
Eye fatigue or strain	____	____	_____
Watery, itching, or burning eyes	____	____	_____
Eye redness or discharge	____	____	_____
Eye pain or headaches	____	____	_____
Other	____	____	_____

YOUR OCULAR HISTORY (Have YOU been diagnosed with any of the following in the past?)

YES NO		YES NO		YES NO	
	Cataracts		Cornea Disease		Retina Disease
	Glaucoma		Crossed Eyes		Injury
	Iritis		Other Eye Disorder		

Cataracts Surgery? YES___ NO____ Date of Surgery: Right Eye_____ Left Eye_____
Do you have a lens implant? YES____ NO____

Retina Surgery? YES___ NO____ Date of Surgery: Right Eye_____ Left Eye_____

Explanation of Eye Injury: _____

YOUR HEALTH HISTORY (please circle Y for Yes OR N for No)

Asthma	Y / N	Diabetes IDDM Type II	Y / N ___# if yrs	Arthritis	Y / N
Kidney Disease	Y / N	Insulin	Y / N	Heart Disease	Y / N
Tuberculosis	Y / N	Head or Spinal Injuries	Y / N	Stroke	Y / N
Carotid Artery-Disease	Y / N	Seizures, Convulsions, Fainting	Y / N	HIV	Y / N
Psychiatric Disorder	Y / N	Any Nervous Disorder	Y / N	Ulcer	Y / N
High Blood Pressure	Y / N	If Yes to High Blood Pressure	___# of yrs	Migraines	Y / N
Rheumatoid Arthritis	Y / N	Sickle Cholesterol	Y / N	Women: Pregnant?	Y / N

Permanent Defect from illness/disease/injury_____ Other_____

NAME and ADDRESS of Family Doctor_____

Doctor's Signature_____ Date_____