

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

If so, what medications? \_\_\_\_\_

Have you had any 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?

- |  |   |
|--|---|
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Blood/Lymph                 | <input type="checkbox"/> Bronchitis           |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Cholesterol          |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Digestive            |
| <input type="checkbox"/> Ears/Nose/Throat            | <input type="checkbox"/> Endocrine            |
| <input type="checkbox"/> Eczema/Rashes               | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Fevers                      | <input type="checkbox"/> Genitourinary        |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Integumentary (Skin) |
| <input type="checkbox"/> Kidney                      | <input type="checkbox"/> Muscle/Bone          |
| <input type="checkbox"/> Neurological                | <input type="checkbox"/> Psychological        |
| <input type="checkbox"/> Respiratory                 | <input type="checkbox"/> Sinus                |
| <input type="checkbox"/> Throat Infections           | <input type="checkbox"/> Thyroid              |
| <input type="checkbox"/> 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

If yes, what kind? \_\_\_\_\_

If yes, what solutions are used? \_\_\_\_\_

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

Would you prefer clear contact lenses or colored contact lenses?  Clear  Colored

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

#### Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

Please check the appropriate boxes below:

	Relationship	
	Mother's or Father's Side	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>

#### For Return Annual Visits

I have reviewed my previous personal, medical, and social history. There have been no changes.

Signature \_\_\_\_\_

Date \_\_\_\_\_

#### HIPAA Notification

I have been informed of the privacy policies in effect at The Eyewear Gallery, Optometrists. I am aware that a copy of the privacy policy is available to me upon request.

Signature \_\_\_\_\_

Date \_\_\_\_\_