ELITE EYE CARE

Please complete the following form as thoroughly as possible.

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

Patient Name: _____ **Date:** _____

Patient Medical History

Current Medications (Rx or Over-the-Counter) (List name of medications: eye drops, vitamins, birth control pills, dosages, and frequency.)

_____

_____

Allergies to Medications or Latex? ☐ Yes ☐ No If so, what medications? _____

_____

Are you currently pregnant or nursing? ☐ Yes ☐ No

Have you ever been diagnosed or treated for any of the following health problems? (please circle)

Constitution
Fatigue
Fevers
Unusual weight loss/gain
Cancer

Ear/Nose/Throat
Hearing loss
Sinusitis
Throat infections

Neurological
Migraines
Multiple sclerosis
Epilepsy
Cerebral palsy
Tumor
Autism spectrum disorder

Psychiatric
Depression
Attention deficit
Anxiety disorder
Bipolar disorder

Cardiovascular
High blood pressure
High cholesterol
Stroke/CVA
Heart disease
Vascular disease
Congestive heart failure

Respiratory
Asthma
Bronchitis
Emphysema

Gastrointestinal
Crohn's Disease
Colitis
Celiac Disease

Hematologic/Lymphatic
Anemia
Ulcer

Allergy/Immune
Environmental allergies
Rheumatoid arthritis
Lupus
Sjogren's syndrome

Muscular/Skeletal
Osteoarthritis
Fibromyalgia
Muscular dystrophy
Ankylosing spondylitis

Integumentary
Eczema
Rosacea
Psoriasis
Herpes simplex
Herpes zoster

Endocrine
Diabetes, type I
Diabetes, type II
Thyroid

Genitourinary
Kidney disease
Prostate disease
STD- herpes/chlamydia

ELITE EYE CARE

Please complete the following form as thoroughly as possible.

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

Patient Name: _____ **Date:** _____

Patient Eye History

Date of Last Eye Exam: _____

By Whom? _____

Have you had any eye-related surgeries of any kind?

☐ Yes ☐ No Explain: _____

_____

Have you ever experienced, been diagnosed or treated for any of the following? (Please circle)

Blurry Vision	Burning
Cataracts	Corneal Abrasions
Crossed eye/Eye turn	Double Vision
Eye infections	Eye injury
Flash of light	Floater/Spots
Glaucoma	Grittiness
Headaches	Iritis/Uveitis
Itchiness	Lazy Eye
Macular Degeneration	Occasional dryness
Retinal Detachment	Sunlight sensitivity
Tearing	Trouble seeing at night
Uncomfortable glasses	

Other eye disorders: _____

Do you use…

Cigarettes or tobacco?	☐ Yes	☐ No
Alcohol?	☐ Yes	☐ No
Other substances?	☐ Yes	☐ No

Hobbies: _____

_____

_____

Family Medical/Eye History

Do you have a family medical history of any of the following? (Please indicate which family member and if applicable maternal/paternal side in the space given)

	Relationship
☐ Cataracts	_____
☐ Macular Degeneration	_____
☐ Glaucoma	_____
☐ Retinal Problems	_____
☐ Diabetes (Type 1 or 2)	_____
☐ High Blood Pressure	_____
☐ Thyroid (High or Low)	_____
☐ Cancer	_____
☐ Other Significant Issues	_____

Lifestyle Questions

Do you… (check all that apply)

☐ …Use digital devices on a regular basis? If yes, how many hours per day? _____ hrs/day

☐ …think you might benefit from thinner, lighter lenses?

☐ …prefer NOT to wear glasses at times?

☐ …spend time outdoors? How often? ____ hrs/wk

☐ …participate in vision-related sports or other activities? If yes, please specify: _____

_____