

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.

Are you currently pregnant or nursing? Yes No  Have you ever been diagnosed or treated for any of the following health problems? (please circle)	atient Name:	D:	ate:		
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 Cardiovascular Muscular/Skeletal Fatigue High blood pressure Osteoarthritis Fevers High cholesterol Fibromyalgia Unusual weight loss/gain Stroke/CVA Muscular dystroph Cancer Heart disease Ankylosing spondy Vascular disease  Ear/Nose/Throat Congestive heart failure Integumentary Hearing loss Eczema Sinusitis Respiratory Rosacea Throat infections Asthma Psoriasis Bronchitis Herpes simplex Neurological Emphysema Herpes zoster Migraines Multiple sclerosis Gastrointestinal Endocrine Epilepsy Crohn's Disease Diabetes, type I	Patient Medical History				
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 Cardiovascular Muscular/Skeletal Fatigue High blood pressure Osteoarthritis Fevers High cholesterol Fibromyalgia Unusual weight loss/gain Stroke/CVA Muscular dystroph Cancer Heart disease Ankylosing spondy Vascular disease  Ear/Nose/Throat Congestive heart failure Integumentary Hearing loss Sinusitis Respiratory Rosacea Throat infections Asthma Psoriasis Bronchitis Herpes simplex Neurological Emphysema Herpes zoster  Migraines Multiple sclerosis Gastrointestinal Endocrine Epilepsy Crohn's Disease Diabetes, type I	•	e-Counter) (List name of medications: eye	e drops, vitamins, birth control		
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Tumor Celiac Disease Thyroid					
Autism spectrum disorder		Cenae Discuse	myrola		
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Psychiatric Anemia Kidney disease	Psychiatric		•		
Depression Ulcer Prostate disease	-		•		
•	·		STD- herpes/chlamydia		
Anxiety disorder Allergy/Immune		Allergy/Immune	- p p		
,	Bipolar disorder				
Rheumatoid arthritis					
Lupus		Lupus			
Sjogren's syndrome					



Please complete the following form as thoroughly as possible.

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Patient Name:	Date:

Patient Eye History	Family Medical/Eye History
Date of Last Eye Exam:	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
Have you had any eye-related surgeries of any kind?	Cataracts
Yes No Explain:	Macular Degeneration
	Glaucoma
Have you ever experienced, been diagnosed or treated for any of the following? (Please circle)	Retinal Problems  Diabetes (Type 1 or 2)
Blurry Vision Burning	High Blood Pressure
Cataracts Corneal Abrasions Crossed eye/Eye turn Double Vision	Thyroid (High or Low)
Eye infections Eye injury	Cancer
Flash of light Floater/Spots	
Glaucoma Grittiness	Other Significant Issues
Headaches Iritis/Uveitis Itchiness Lazy Eye	Lifestule Questions
Macular Degeneration Occasional dryness	Lifestyle Questions
Retinal Detachment Sunlight sensitivity	
Tearing Trouble seeing at night	Do you (check all that apply)
Uncomfortable glasses	— (check all that apply)
Other eye disorders:	Use digital devices on a regular basis? If yes,
Do you use	how many hours per day? hrs/day
Cigarettes or tobacco? Yes No	think you might benefit from thinner, lighter
Alcohol? Yes No	lenses?
Other substances? Yes No	prefer NOT to wear glasses at times?
Hobbies:	spend time outdoors? How often? hrs/wk
	participate in vision-related sports or other
	activities? If yes, please specify: