New Patient Case History (Adult)

Date: _____________

Name: ____ Birthdate: ____________ Male ___ Female___

Last First MI **Social Security #: _____________________**

Address: __________________________City: ________________ St: _____ Zip: _______ Ph#:________________

Email Address: _________________________@___________________Cell Ph#: ________________________

Occupation: ______________________ Employer: ______________________ Wk #: _______________ext______

Marital Status: S_____ M_____ D_____ W_____ Separated_____

Spouse's name: ________________ Spouse's Employer: __________________ Wk#: _______________ext______

Whom may we contact in case of an emergency? _______________________________ Ph#:_________________

Whom should we list as head of household? ______________ Payment Method for today's charges? ______________

Vision Ins. Co.: _____________________________ Secondary Vision Ins Co.: ____________________________

Health Ins. Co.: _____________________________ Secondary Health Ins Co.: ____________________________

How did you hear about our office?: ____

Medical History

Physician: ___________________ Ph.#: ____________ Address:________________ Date of last exam?: _________

Previous Operations and When: ____

Are you currently being treated for any medical condition(s)? Y / N (Please Specify) __________________________

Alcohol / Drug / Tobacco use? If yes, circle which and state frequency of use: _________________________________

Please check all that apply:

__AIDS
__Allergies/Hay Fever
__Allergies to meds
which: __________________
____
__Asthma
__ Cancer
Type: _____________
____
Diabetes:
Type: ___A1C:____Yrs__

__Epilepsy
__Hearing Problems
__Heart Condition:
____
____
__High Blood Pressure
__High Cholesterol
__Kidney Disease
__Liver Disease
__Low Blood Pressure

__Lung Disease
__Migraine Headaches
__Muscle/Bone Disease
____
____
__Neurological Problems
____
____
Pain Scale Today (Circle)
1 2 3 4 5 6 7 8 9 10

__Previous Head Injury
__Sinus Problems
__Skin Problems
__Speech Problems
__STD _____________
__Stomach Problems
__Stroke
__Thyroid (High / Low)
__Other ____________

List below **or provide a separate list** of all medications, vitamins, supplements, etc. and include reason for taking. (Please include both prescribed and over the counter.)

__________________ __________________ __________________ __________________

__________________ __________________ __________________ __________________

Preferred Language____________ Race _______ (Hispanic) Y / N Height_______ Weight_______

Headache History

How frequent? ________ Where located? ___________ Which side of head? ___________ Type of pain? ____________

When do they begin? Awaken with it ____ Afternoon ____ Evening ____ How long do they last? ______________

What do you do for relief? _____________ Do they affect your vision? Y / N If so, how? __________________________

Immediate Family Health History

___Cancer Relationship_______________
___Diabetes Relationship_______________
___Heart Condition Relationship_______________
___High Blood Pressure Relationship_______________
___High Cholesterol Relationship_______________
___Thyroid Condition Relationship_______________

___Glaucoma Relationship_______________
___Lazy Eye Relationship_______________
___Macular Degen. Relationship_______________
___Turned Eye Relationship_______________
___Other_____________________________________

Eye/Ocular Health

Have you had a vision exam? Yes___ No___ When: _____________ Previous Eye Doctor: ________________________
Do you currently wear? Eyeglasses ___ Date Prescribed: _________ Contact Lenses ___ Date Prescribed: __________
When did you first start wearing glasses/contact lenses: ____________ Type of Contact Lenses? ____________________
If you don't currently wear contacts, are you interested in wearing them? Yes __ No __ Not Sure __
Please check all that applies:

__Aching Eyes; Pain Scale______
__Blindness
__Blur at Far Distance (c, s Rx)
__Blur at Near Distance (c, s Rx)
__Burning Eyes
__Double Vision
__Dry Eyes
__Eye Fatigue/Strain
__Itching Eyes
__Lazy Eye
__Light Sensitivity
__Loss of Vision
__Previous Reaction to Eye Drops
__Previous Vision Therapy
__Red eye(s)
__Reduced Depth Perception
__Reduced Eye-Hand Coordination
__Seeing Black Floating Spots
__Seeing Flashing Lights
__Turned Eye(s)
__Watering Eyes
__Other:____________________________
____
____

Please list any previous eye injuries, surgeries, or diseases and specify when:
Eye Injury: ____
Eye Surgery: ____
Eye Disease: ____

Did you sustain an eye injury at work? Y / N If so, are your eye injuries accident related? Y / N

Presently using medications for any eye condition? Yes__ No__ (IF yes, please list below.)
Meds: For what condition:

_________________________________ ____
_________________________________ ____
_________________________________ ____

Eyewear Lifestyle Profile

Do you intend to order new eyewear today? Y / N / Not Sure
Things that bother you about your current eyewear:

__Bifocal line annoying
__Corrode
__Do not like frame
__Frames too large
__Frames too small
__Lenses scratched
__Lenses too thick
__Needs adjusted frequently
__Not enough reading area
__Sensitive to car lights
__Sensitive to fluorescent lights
__Sensitive to snow
__Sensitive to sun
__Sore on nose/ears
__Slip down
__Tint too dark
__Too heavy
__Other_____________________
____

How do you use your eyes while at work/home? Computer___ Desk Work___ Driving___ Reading___ Other_________
Check if you have any of the following: Computer Eyewear__, Eyewear for Glare__, Safety Eyewear ___, Sports Eyewear__, Sunglasses ___, Spare/Backup Eyewear ___, Other _______________________________________
Mark or list the following activities you perform:

__Art Work
__Baseball/Softball
__Basketball
__Bicycling
__Boating/Fishing
__Card playing
__Computer
__Contact Sports
__Gardening
__Golf
__Home Workshop
__Jogging/Running
__Motorcycling
__Music
__Needlework/Sewing
__Reading
__Shooting/Hunting
__Skiing
__Soccer
__Swimming/Scuba
__Tennis/Racquetball
__Video Games
__Other________________
____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.
Signature ____

______
______