Patient Case History (Adult)
Please update this case history form as completely and accurately as possible.
This is being requested in order that we may provide you with the very best in vision care.

Date: _____

Name: (Last):_____(First):_____(MI):_____

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.: _____

Are you covered under a union/military policy? Y / N
Circle which applies for today's visit: Pre-Scheduled last year, Post card, Other: _____

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 _____

Preferred Language_____ Race_____ (Hispanic) Y / N Height_____ Weight_____

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.)

_____ _____ _____ _____

_____ _____ _____ _____

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_____
___ Lazy Eye Relationship _____

___Blindness Relationship_____
___Cataracts Relationship_____
___Glaucoma Relationship_____
___Turned Eye Relationship_____
___Macular Degen. Relationship_____
___Other_____

(OVER)