Eyecare Associates

Your Lifetime Vision Source

www.visionsource-marshalltowneyecare.com

WELCOME BACK TO OUR OFFICE

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

Today's Date _____

Last _____ First _____ MI ____

Street _____

City _____ State _____ Zip Code _____

Home Phone _____ OK to contact Y / N

Work Phone _____ OK to contact Y / N

Cell Phone _____ OK to contact Y / N

Best time/# to call _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Date of Birth _____ Age _____ Sex M F

Email Address _____

Spouse Date of Birth (or Parent's) _____

Spouse Name (or Parent's) _____

Spouse Work (or Parent's) _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office for your needs?

- ❑ Another Dr.
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages: Which directory? _____
- ❑ Web Page: Which Web Site? _____
- ❑ Other _____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN/ID# _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN/ID# _____

Subscriber Birth Date _____

Secondary Medical Insurance _____

Subscriber Name _____

Subscriber SSN/ID# _____

Subscriber Birth Date _____

Do you participate in a flex spending account? ❑ Yes ❑ No

How will you settle for your account today?

❑ Cash ❑ Check ❑ Credit Card

Patient Medical History

Name of Family Physician _____

Town _____

Date of Last Physical Check-up _____

Do you consent for information to be sent to your physician Y / N

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to Medication: ❑ Yes ❑ No

List _____

Have you ever been diagnosed or treated for the following?

- ❑ Allergies
- ❑ Asthma
- ❑ Arthritis
- ❑ Cancer
- ❑ Cholesterol
- ❑ Depression
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney
- ❑ MS
- ❑ Nerves
- ❑ Current Pregnancy
- ❑ Stroke
- ❑ Thyroid
- ❑ Ulcer

Others _____

Social History/Hobbies _____

Current Occupation _____

Adult (16 and over)

Do you drink alcohol? Yes / No If yes, amt. _____

Do you smoke? Yes / No If yes, amt. _____

Child (15 and under)

Were you normal birth weight and time? Y / N If no, explain _____

Have you had normal development? Y / N If no, explain _____

Any problems in school? Y / N If yes, explain _____

Family Medical/Eye History (check all that apply)

Is there a family history of any of the following?

	Relationship
Blindness	❑
Cataracts	❑
Corneal Problems	❑
Glaucoma	❑
Lazy Eye	❑
Macular Degeneration	❑
Retinal Problems	❑
Diabetes	❑
Heart Disease	❑
Hypertension (Blood Pressure)	❑
Stroke	❑
Kidney Disease	❑
Lupus	❑
Thyroid Disease	❑
Other	❑

History Reviewed ❑ No changes ❑ Changes noted ❑ Pt. Oriented TPP

Physician's Signature _____

2nd Review _____

3rd Review _____

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind? _____

Solutions Used _____

Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____

Have you ever tried contact lenses? ❑ Yes ❑ No

Are you interested in wearing contact lenses? ❑ Yes ❑ No

Do you... (Check box if your answer is yes)

❑ Work at a computer?
❑ Think you might benefit from thinner, lighter lenses?
❑ Have interest in a "Test Drive" of the latest contact lens designs
❑ Spend time outdoors? (How much?) _____hrs/week
❑ Have prescription sunglasses?
❑ Prefer not to wear your glasses at times?
❑ Want information on Laser Vision Correction surgery?
❑ Have interest in a non-surgical approach to vision correction?
❑ Have more than 1 pair of current Rx glasses?
❑ Have children?
❑ Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you?

❑ Yes ❑ No

If you wear contact lenses, are you having problems with the vision and comfort?

❑ Yes ❑ No

Have you ever been diagnosed or treated for the following?

❑ Cataracts
❑ Corneal Abrasion
❑ Eye infection
❑ Eye injury
❑ Glaucoma
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Macular Degeneration
❑ Retinal Detachment
❑ Other eye disorders

Do you experience or have you ever experienced?

❑ Blurry vision
❑ Burning
❑ Tearing
❑ Headaches
❑ Flash of light
❑ Eye Fatigue
❑ Floater/spots
❑ Grittiness
❑ Itchiness
❑ Double vision
❑ Sunlight Sensitivity
❑ Crossed eye/eye turn
❑ Trouble seeing at night
❑ Uncomfortable glasses
❑ Occasional dryness