

Name: _____ Date: _____

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

Patient Medical History	Patient Eye History																																																																																	
Name of Family Physician _____ Town _____ Date of Last Physical Check-up _____ CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) or provide a list for photocopying... _____ _____ Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____ Allergic to LATEX? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any recent surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Description: _____ Do you have a PACEMAKER? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use cigarettes / tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use alcohol / other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been diagnosed or treated for the following health problems? <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%; text-align: center;">Yes</th> <th style="width: 15%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Allergy/Auto-Immune</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Muscle/Bone</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Respiratory (Asthma)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Blood/Lymphatic (Hepatitis, cancer)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Cardiovascular (♥,BP, cholesterol)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Gastrointestinal (digestive)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Ears/Nose/Throat/Mouth</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Endocrine (Thyroid/Diabetes)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Constitutional Symptoms (fever, fatigue, weight loss/gain)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Reproductive/Urinary</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Integumentary (Skin)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Neurological/Headaches</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> <tr> <td>Psychiatric</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Description: _____</td> </tr> </tbody> </table>		Yes	No	Allergy/Auto-Immune	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Respiratory (Asthma)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Blood/Lymphatic (Hepatitis, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Cardiovascular (♥,BP, cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Gastrointestinal (digestive)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Endocrine (Thyroid/Diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Constitutional Symptoms (fever, fatigue, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Reproductive/Urinary	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Neurological/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Description: _____			Date of Last Eye Exam _____ By Whom? _____ Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Brand/Type? _____ Solutions used _____ <i>Date glasses last updated:</i> _____ Have you ever had... Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Description: _____ Eye Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Description: _____ <div style="background-color: #cccccc; text-align: center; padding: 2px;">Lifestyle</div> Do you.....(check box if your answer is yes) <input type="checkbox"/> ..work at a computer? _____Hrs/week <input type="checkbox"/> ..spend time outdoors? How much? __Hrs/week <input type="checkbox"/> ..have prescription sunwear? <input type="checkbox"/> ..have an interest in contacts? <input type="checkbox"/> ..want information on Laser Vision Correction surgery? <input type="checkbox"/> ..have more than one pair of current Rx eyewear? <input type="checkbox"/> ..have children or family members in need of eyecare? <div style="background-color: #cccccc; text-align: center; padding: 2px;">Family Medical/Eye History (Check all that apply)</div> Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes – please check box and list mother’s / father’s side) Blindness <input type="checkbox"/> _____ Cataracts <input type="checkbox"/> _____ Corneal Problems <input type="checkbox"/> _____ Diabetes <input type="checkbox"/> _____ Glaucoma <input type="checkbox"/> _____ Heart Disease <input type="checkbox"/> _____ Lazy Eye <input type="checkbox"/> _____ Macular Degeneration <input type="checkbox"/> _____ Retinal Problems <input type="checkbox"/> _____ 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? <input type="checkbox"/> Another Doctor <input type="checkbox"/> Insurance List <input type="checkbox"/> Saw Sign/Building <input type="checkbox"/> Newspaper/Radio/TV <input type="checkbox"/> Yellow Pages: Which directory? _____ <input type="checkbox"/> Web Page: Which Web Site? _____ <input type="checkbox"/> Other _____
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Helena Vision Center P.C.

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