SCOTT
EYE CARE

Welcome To Our Office!

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.

Date: _____

Patient Information

Last: _____

First: _____MI: _____

Street: _____

City: _____State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

How do you prefer to be contacted?

(Indicate #1 and #2 preference):

Home #___Work #___Cell #___Text___Email____

Patient's SSN: _____

Date of Birth: _____Age: _____

Sex: M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

Spouse (or Parent's Work): _____

How did you first hear about our office?

☐ Friend or Relative. Whom may we thank for the referral? _____
☐ Another Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Facebook
☐ Yellow Pages: Which directory? _____
☐ Online Search
☐ Other: _____

Vision Questions

What is/are your main reason(s) for your visit today?

_____

_____

_____

Do you currently wear vision correction? (Check all that apply)

☐ Glasses ☐ Contact Lenses ☐ Neither

What difficulties are you having with your current glasses or contacts?

_____

_____

Are you interested in trying contact lenses?

☐ Yes ☐ No ☐ Possibly

If yes, what type of contact lenses? (Check all that apply)

☐ Daily ☐ Monthly ☐Colors ☐Other

Lifestyle Questions

Do you…(check all that apply):

☐ …use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
☐ …think you might benefit from thinner, lighter lenses?
☐ …prefer NOT to wear glasses at times?
☐ …spend time outdoors? How often? ____hrs/week
☐ …participate in vision-related sports or other activities?

If yes, please specify:_____

_____

_____

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Patient Medical History Form

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.

Patient Name: _____

Date: _____

Patient Eye History

Date of Last Eye Exam: _____

By Whom? _____

Have you had any eye-related surgeries of any kind?
☐ Yes ☐ No

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision
☐ Burning
☐ Cataracts
☐ Corneal Abrasions
☐ Crossed eye/Eye turn
☐ Double Vision
☐ Eye Infections
☐ Eye Injury
☐ Flash of light
☐ Floaters/Spots
☐ Glaucoma
☐ Grittiness
☐ Headaches
☐ Iritis/Uveitis
☐ Itchiness
☐ Lazy Eye (Amblyopia)
☐ Macular Degeneration
☐ Occasional dryness
☐ Retinal Detachment
☐ Sunlight Sensitivity
☐ Tearing
☐ Trouble seeing at night
☐ Uncomfortable glasses
☐ Other eye disorders: _____

Family Medical/Eye History

Do you have a family medical history of any of the following? (check all that apply and indicate mother or father's side):

	Relationship (Mother's or Father's side)
Blindness	☐ _____
Cataracts	☐ _____
Corneal Problems	☐ _____
Diabetes	☐ _____
Glaucoma	☐ _____
Heart Disease	☐ _____
Lazy Eye	☐ _____
Macular Degeneration	☐ _____
Retinal Problems	☐ _____

Continued on next page…

Patient Medical History Form, Continued

Patient Medical History

Name of Family Physician: _____

_____

Address: _____

Date of Last Physical Check-Up: _____

Height:_____Weight:_____

Females: Are you pregnant or nursing?
☐Yes ☐No

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency. Please bring a list if possible!):_____

_____

_____

_____

_____

_____

Allergies to medications? ☐Yes ☐No

If so, what medications? _____

_____

_____

Do you use cigarettes/tobacco? ☐Yes ☐No

Alcohol? ☐Yes ☐No

Other substances? ☐Yes ☐No

Patient Medical History, Cont.

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
If yes: Last A1c:_____		
Digestive	☐	☐
Ears/Nose/Throat Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
HIV	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐