NAME_____________________________________

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

Patient History

Do you……(check box if your answer is yes)

- ☐ work at a computer?
- ☐ think you might prefer thinner, lighter lenses?
- ☐ have interest in a 1 week trial of the latest contact lens designs?
- ☐ spend time outdoors? How much? _____Hrs/week
- ☐ have prescription sun wear?
- ☐ enjoy fishing, boating or skiing?
- ☐ prefer not to wear your glasses at times?
- ☐ have more than 1 pair of current Rx eyewear?

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

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

Date of Last Eye Exam ___________________________

By Whom? ____________________________________

Do you wear glasses?(circle) Distance, Near, Bifocal

Have you ever tried contact lenses? Yes No

Are you interested in trying contact lenses? Yes No

Do you currently wear contact lenses? Yes No

What kind? _____________________________________

Solutions used___________________________________

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Would you prefer contacts that do not require daily cleaning? Yes No

Family Physician_________________________________

Location____

Date of Last Physical Check-up______________________

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills, dosage and what they treat)

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Has a blood relative ever been diagnosed with the following? If yes, what is their relationship to you?

- ❏ Blindness __________________________
- ❏ Cataracts at young age __________________________
- ❏ Corneal Problems __________________________
- ❏ Diabetes __________________________
- ❏ Glaucoma __________________________
- ❏ Heart Disease __________________________
- ❏ Lazy Eye __________________________
- ❏ Macular Degeneration __________________________
- ❏ Retinal Problems __________________________

Are you nursing/pregnant? Yes No

Any allergies to medications? Yes No
If so, what medications? ____

Have you had any eye surgeries? Yes No

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

Have you ever been diagnosed or treated for the following health problems? (check any that apply)

❏ Allergies ☐ High Blood Pressure ☐ High Cholesterol ☐ Unusual weight losses/gains
❏ Diabetes/Endocrine ☐ Thyroid ☐ Digestive ☐ Genitourinary
❏ Kidney ☐ Ears/Nose/Throat ☐ Blood/Lymph ☐ Immunologic
❏ Skin/ Eczema/Rashes ☐ Arthritis ☐ Neurological ☐ Psychological
❏ Respiratory ☐ Cancer

Current blood pressure if known: ________ / _________
Height and weight _______ Ft _______ in _________ lbs