

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

### Patient Medical History

Name of Family Physician \_\_\_\_\_  
 City \_\_\_\_\_  
 Date of Last Physical Check-up \_\_\_\_\_

**CURRENT MEDICATIONS (Rx or Over the Counter)**  
 (List name of medications including eye drops, vitamins, & birth control pills) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies to medications?  Yes  No  
 If so, what medications? \_\_\_\_\_  
 \_\_\_\_\_

Have you had any 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?**

	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

### Patient Eye History

Date of Last Eye Exam \_\_\_\_\_  
 By Whom? \_\_\_\_\_

Have you ever tried 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 clear contact lenses or colored contact lenses?  Clear  Colored

If you wear bifocals, do the lines or head tilting bother you?  Yes  No

### Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:  
 No  Yes (Please check boxes)

	Relationship (Mother's or 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"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Cy-Fair Eyecare.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.  
 CC#: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

Signature \_\_\_\_\_