How Did you Hear About US?????

From a Friend — Internet
Saw the Signs — News Paper
Post Card — Phone Call
Code from Marketer

Existing Patient? Yes or No
New Patient? Yes or No
Who Referred You???
Name_________________________

The Optometric Eye Site

Case History Form

Name ____________________________________ Social Security ________________________Date ____ /____ /____

Address ____ Phone Number ____ - ____ - ____

City ____________________________ State______ Zip Code ______________ Date of Birth ____/ ____ /____

Gender: Male/ Female Occupation_________________________ Employer________________________________

Email Address________________________________

The Doctor would like to dilate your eyes today; it is an important part of the eye exam. We can provide you with disposable sunglasses to help with light sensitivity. If you don't want to be dilated, please sign below and circle **NO**. If you have concerns, please consult with our staff. Please note, additional charges may apply.

Circle: Yes or No Signature ___________________________ Guardian's Signature __________________________

Medication & Allergy Information

Penicillin Allergy? **Yes** or **No**	Sulfa Allergy? **Yes** or **No**	Seasonal Allergies? **Yes** or **No**	Other Allergies:	List **all** medications you are currently taking:

Review of Systemic Health

Please check below if you have any of the following diseases

Systemic Health	**Yes**	**No**	**Visual Health**	**Yes**	**No**
Heart Problems (Chest pain, irregular heartbeat, etc…)			Blurry Vision		
Respiratory Problems (Shortness of breath, cough, etc…)			Dry Eye, Watery Eye		
Urinary Tract Problems(Pain, discomfort, red urine)			Double Vision		
Skin Problems (Rashes, dryness, rosacea)			Floaters, Flashing Light		
Musculoskeletal Problems (Arthritis, joint pain)			Headaches		
Neurological Problems (Numbness, weakness, paralysis)			Red Eyes		
Psychiatric Problems (Depression, anxiety)			Light Sensitive		
Chronic Fever, Unexpected Weight Gain, Fatigue			Eye Pain		
Ear/Nose/ Throat (Hearing loss, sinus or sore throat)			Waviness in vision		
Endocrine Problems(Diabetes, Thyroid Disease)			Loss of your peripheral vision		
High Blood Pressure			Color Vision Loss		

Health History: Please indicate below if you ***(s)*** or an immediate family member ***(f)*** has any of the following :

Cataracts	(s/f)	High Blood Pressure	(s/f)	Heart Disease	(s/f)	Lazy Eye	(s/f)
Glaucoma	(s/f)	Bleeding Problems	(s/f)	Tuberculosis	(s/f)	Arthritis	(s/f)
Blindness	(s/f)	Sinus Problems	(s/f)	Bronchitis	(s/f)	Headaches	(s/f)
Diabetes	(s/f)	Retinal Detachment	(s/f)	Stroke	(s/f)	Liver Disease	(s/f)
Migraines	(s/f)	Asthma	(s/f)	HIV	(s/f)		

Other disease(s) not listed:

Surgeries: Please list any previous surgeries below. (Please include eye and non- eye related surgeries.)

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Do you smoke? **Yes** or **No** Do you drink alcohol? **Yes** or **No** Do you use recreational drugs? **Yes** or **No**

The Optometric Eye Site (www.theeye-site.com)