Vision West Eye Care
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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): _____

If not referred, how did you choose our office?
☐Friend or Relative
☐Another Doctor
☐Insurance List
☐Saw Sign/Building
☐Newspaper/Radio/TV
☐Online. If yes, where did you find us? _____
☐Other: _____

Insurance Information

Vision Insurance:_____

Primary Medical Insurance:_____

Secondary Medical Insurance:_____

Lifestyle Questions

Do you…(check all that apply):

☐…use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
☐…currently wear contacts/ would like to wear contacts
☐…spend time outdoors? How often? ____hrs/week
☐…need safety eyewear

Health History

Primary Care Physician:

Name:_____

Location:_____

Date of Last Visit:_____

Height:_____ Weight:_____

Date of Last Eye Exam:_____

By Whom? _____

Patient Eye History

Have you had any eye-related surgeries of any kind?

☐Yes ☐No

If so_____

Are you currently experiencing 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 ☐Amblyopic

☐Macular Degeneration ☐dry/watery eyes

☐Retinal Detachment ☐Sunlight Sensitivity

☐Retinal Tearing ☐Trouble seeing at night

☐Uncomfortable glasses ☐Other eye disorders

Patient Medical History

Current Medications (Rx and Supplements):

_____

_____

_____

Allergies to medications? ☐Yes ☐No

If so, what medications? _____

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

Family Medical/Eye History

Do you have a family medical history of any of the following?

	Relationship to you
Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Diabetes	☐_____
Glaucoma	☐_____
Amblyopia	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____

Patient Medical History

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

	Yes	No
Environment Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Thyroid	☐	☐