THE EyeCare center

Welcome to the office of
Dr. Chad Thompson and Dr. Kurt Olson

Today's Date _____

Patient Information

First _____ MI _____
Last _____
Date of Birth _____ Age _____ Sex M F
Spouse or Parent/Guardian _____
Street _____
City _____ State _____ ZIP _____
Home Phone _____
Work Phone _____
Cell Phone _____
E-mail _____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Emergency Contact Name _____
Emergency Contact Phone _____

How would you prefer we contact you?
☐ Home ☐ Work ☐ Cell ☐ E-mail

What is the major purpose of this visit?

_____

Do you currently wear ☐ glasses? ☐ contact lenses?

Any problems with your current contact lenses or glasses?

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend, relative or Dr. _____

If not referred, how did you choose our office?
☐ Newspaper Ad ☐ Yellow Pages
☐ Radio Ad ☐ Other _____

Insurance Information

Please present all medical insurance cards.
Please note insurance does NOT cover the Contact Lens Evaluation

Primary Medical Insurance _____
Subscriber Name _____
Subscriber ID# _____ Birth Date _____

Secondary Medical Insurance _____
Subscriber Name _____
Subscriber ID# _____ Birth Date _____

Who is responsible for your account?
☐ Self ☐ Other _____

Lifestyle Questions

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

☐ ...work at a computer?
☐ ...think you benefit from thinner, lighter lenses?
☐ ...have interest in a "test drive" of the latest contact lens designs?
☐ ...spend time outdoors? How much? _____ hrs/week
☐ ...have prescription sunwear?
☐ ...prefer not to wear your glasses at times?
☐ ...want information on Laser Vision Correction surgery?
☐ ...have more than one pair of *current* Rx eyewear?
☐ ...have children under 20? What age(s)? _____
☐ ...have family members in need of eyecare?
☐ ...have an East-West commute?
☐ ...experience glare or halos in vision when driving at night?

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Do you currently see another eye specialist? ☐ Yes ☐ No
If so, who? _____

Have you had an eye surgery or injury? ☐ Yes ☐ No
If so, describe: _____

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 or colored contact lenses?
☐ Clear ☐ Colored

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

☐ Blurred Vision
☐ Cataracts
☐ Crossed Eye/Eye Turn
☐ Eye Infections
☐ Flashes of Light
☐ Glaucoma
☐ Headaches
☐ Itchy Eyes
☐ Macular Degeneration
☐ Retina Detachment
☐ Watery Eyes
☐ Uncomfortable Glasses
☐ Burning Eyes
☐ Cornea Abrasions
☐ Double Vision
☐ Eye Injury
☐ Floaters/Spots in Vision
☐ Gritty Feeling Eyes
☐ Iritis/Uveitis
☐ Lazy Eye (Amblyopia)
☐ Occasional Dryness
☐ Sunlight Sensitivity
☐ Trouble Seeing at Night
☐ Other Eye Disorders

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

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

Is there a family history of any of the following:

	Relationship *(Immediate family only)*
Blindness	☐ _____
Cataracts	☐ _____
Cornea Disorders	☐ _____
Diabetes	☐ _____
Glaucoma	☐ _____
Heart Disease	☐ _____
Lazy Eye	☐ _____
Macular Degeneration	☐ _____
Retina Disorders	☐ _____
Stroke	☐ _____
Cancer	☐ _____

Patient Social History

Do you use cigarettes/tobacco products? ☐ Yes ☐ No

Do you use alcohol products?
☐ No ☐ Yes, frequently ☐ Yes, occasionally

Do you use illegal drugs? ☐ Yes ☐ No
If so, what type? _____

Have you been exposed to or infected with:
☐ Gonorrhea ☐ Hepatitis ☐ HIV
☐ Syphilis ☐ Herpes ☐ None

Patient Medical History

Name of Family Physician _____
City _____
Date of Last Medical Exam _____
Name of Pharmacy _____
City _____

CURRENT MEDICATIONS (Rx or Over the Counter)
List name of all medications including vitamins, herbs, and birth control pills. Please provide list if available.)

_____
_____
_____
_____
_____

CURRENT EYE DROPS (Rx or Over the Counter)

_____
_____

Do you have allergies to medications? ☐ Yes ☐ No
Is so, what medications? _____

Are you pregnant or nursing? ☐ Yes ☐ No
If pregnant, what is expected delivery date? _____

Have you had any major surgeries? ☐ Yes ☐ No
If so, please list and provide approximate date for each.

_____
_____

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

	Y	N
CONSTITUTIONAL		
Unusual weight losses or gains	☐	☐
Fevers	☐	☐
INTEGUMENTARY (skin)	☐	☐
NEUROLOGICAL		
Migraines	☐	☐
Seizures	☐	☐
ENDOCRINE (thyroid/other gland)	☐	☐
CANCER	☐	☐
EARS / NOSE / MOUTH / THROAT		
Allergies	☐	☐
Sinus	☐	☐
RESPIRATORY		
COPD/Emphysema	☐	☐
Asthma	☐	☐
VASCULAR / CARDIOVASCULAR		
Diabetes	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
GASTROINTESTINAL (stomach/intestines)	☐	☐
GENITOURINARY (kidney/bladder/prostate)	☐	☐
BONES / JOINTS / MUSCLES		
Arthritis/Chronic Pain	☐	☐
LYMPHATIC / HEMATOLOGIC (lymph/blood)	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC / MENTAL	☐	☐

Please briefly explain any YES answers:

_____
_____

Doctor's Signature _____ **O.D.** **Date** _____