NEVADA EYE CARE OPTOMETRY
Caring for YOU Like Family

PATIENT INFORMATION **DATE: _____**

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ SS# _____ Sex: M / F Marital status: Single / Married

Home Phone _____ Cell Phone_____ Work Phone _____

Email _____Preferred Contact order: Cell ___Home ___ Work___ Email: ___

Occupation_____ Name of Employer_____

HOW DID YOU FIND US? Family/Friend/Google/Yelp/Our Website /Insurance Website / Newspaper /Other_____

YOUR INSURANCES

Medical Plan_____ ID # _____ Group # _____

Member Name_____ Member birth date _____ Member phone _____

Member address _____ City _____ State ____ Zip: _____

Member SS# _____ Relationship to member_____ Sex: M/ F

Member Employer/address _____ _____Occupation_____

Vision Plan _____ ID# _____ Group # _____

Member Name _____ Member birth date _____ Member phone_____

Member address _____ City _____ State ____ Zip _____

Member SS# _____ Relationship to member_____ Sex: M / F

Member Employer/address _____ Occupation _____

CHIEF COMPLAINT and PERSONAL HISTORY

Main reason for your visit? _____

List ALL Medications and vitamins you are taking_____

_____

List Drug and Environmental Allergies_____

Date of Last Physical _____ Surgeries and Dates _____

Have you ever used? Tobacco Yes / No / Never Alcohol Yes / No / Never Recreational Drugs Yes / No / Never

Family Doctor Name _____Phone_____ Fax _____

Address _____ City _____ State _____ Zip _____

THANK YOU FOR CHOOSING NEVADE EYE CARE OPTOMETRY!

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

Patient Medical History

History of Present Illness: Have you ever been treated or diagnosed for the following eye problems?

- ❑ Blurry Vision
- ❑ Burning
- ❑ Cataracts
- ❑ Corneal Abrasions
- ❑ Crossed eye/Eye turn
- ❑ Double Vision
- ❑ Eye Infections
- ❑ Eye Injury
- ❑ Flash of light
- ❑ Floaters/Spots
- ❑ Glaucoma
- ❑ Gritty/Sandy Eyes
- ❑ Headaches
- ❑ Iritis/Uveitis
- ❑ Itchiness
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Dry Eyes
- ❑ Retinal Detachment
- ❑ Sunlight Sensitivity
- ❑ Tearing
- ❑ Trouble seeing at night
- ❑ Color Blindness
- ❑ Other eye disorders/surgery_____

Are you currently pregnant or nursing? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergic/Immunologic/Lupus	❑	❑
HIV/AIDS	❑	❑
Arthritis	❑	❑
Musculoskeletal	❑	❑
Cardiovascular disease/stroke	❑	❑
High Blood Pressure	❑	❑
Cholesterol	❑	❑
Gastrointestinal Problems	❑	❑
Digestive (GERD, IBS)	❑	❑
Neurological Problems	❑	❑
MS/Parkinson/Epilepsy	❑	❑
Constitutional Problems	❑	❑
Unusual weight losses/gains	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Trauma	❑	❑
Genitourinary	❑	❑
STD, herpes, chlamydia	❑	❑
Psychiatric/depression/panic	❑	❑
Ears/Nose/Throat	❑	❑
Throat Infections	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Bronchitis	❑	❑
Asthma	❑	❑
Endocrine	❑	❑
Diabetes	❑	❑
Thyroid	❑	❑
Integumentary (Skin)	❑	❑
Eczema/Rashes	❑	❑
Rosacea	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____
Date of Last Dilation _____
Would you like to be dilated today: ❑ Yes ❑ No
Do you wear glasses? ❑ Yes ❑ No
If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No
Are you interested in contact lenses? ❑ Yes ❑ No
If No, skip to Family Medical/Eye History
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

Family Medical/Eye History (Check all that apply)

Is there a family medical history (mother, father, brother, sister, relatives) of any of the following:

❑ No ❑ Yes (Please check boxes and list relationship)

- Blindness ❑_____
- Cataracts ❑_____
- Corneal Problems ❑_____
- Diabetes ❑_____
- Glaucoma ❑_____
- Heart Disease ❑_____
- Lazy Eye ❑_____
- Macular Degeneration ❑_____
- Retinal Problems ❑_____
- Arthritis ❑_____
- Cancer ❑_____
- Strabismus ❑_____

_____ _____
Signature of Patient/Responsible Party Date