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_____
Town_____
Date of Last Physical Checkup_____

Current Medications (RX or Over the Counter)
(Please list name of medications including eye drops, vitamins, and birth control pills)

_____
_____
_____
_____
_____

Allergies to medications? Yes / No
If so, what medications?_____
_____

Have you had any surgeries?
Do you use any of the following substances?
(Check if yes)

- ○ cigarettes/tobacco
- ○ alcohol
- ○ other

Have you ever been diagnosed or treated for the following health problems?
(Check if yes)

- ○ Allergies
- ○ Arthritis
- ○ Blood/Lymph
- ○ Bronchitis
- ○ Cancer
- ○ Cholesterol
- ○ Diabetes
- ○ Digestive
- ○ Ear/Nose/Throat
- ○ Eczema/Rashes
- ○ Fatigue
- ○ Fevers
- ○ Genitourinary
- ○ Hep C/HIV/AIDS
- ○ High Blood Pressure
- ○ Integumentary (skin)
- ○ Kidney
- ○ Muscle/Bone
- ○ Neurological
- ○ Psychological
- ○ Respiratory
- ○ Sinus
- ○ Throat Infections
- ○ Thyroid
- ○ Unusual weight losses/gains

Patient Eye History

Date of last eye exam_____
By whom?_____

Do you currently wear contact lenses?
If yes:
What kind?_____
Solutions used_____
Are you satisfied with the comfort? Yes / No
Are you interested in a “test drive” of the latest contact lens designs? Yes / No

If no:
Have you ever tried contact lenses? Yes / No
Are you interested in contact lenses? Yes / No
Are you interested in colored lenses? Yes / No

Family Medical History

Is there a family history of any of the following?
(Check if yes)

- ○ Blindness
- ○ Cataracts
- ○ Glaucoma
- ○ Macular Degeneration
- ○ Retinal Problems
- ○ Corneal Problems
- ○ Lazy Eye/Eye Turn
- ○ Diabetes
- ○ HTN
- ○ Cancer
- ○ Thyroid Disease

I acknowledge that I have read, or had the opportunity to read if I so chose, and understood the Notice of Privacy Practices (NPP) and agree to its terms.

Signature_____

Date_____

COLUMBIA POINT
VISION CLINIC

WELCOME TO OUR OFFICE

Patient Information

Today's Date_____
Last_____
First _____M_____
Street_____
City_____State_____ Zip_____
Date of Birth_____ Age_____
Home Phone_____
Work Phone_____
Cell Phone_____
Email Address_____
How do you prefer to be contacted?
(Indicate #1 & #2 choice)
Home#____Work#____Cell#___Text___Email___
Patient's SSN_____
Employer (or School)_____
Occupation (or Grade)_____
Spouse (or parent's name)_____
Spouse (or parent's work)_____
Sex M F

What is the major purpose of this visit?

_____
Are there 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 or relative_____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw roadside Billboard/Building
- Newspaper/Radio/TV
- Yellow Pages: Which Directory?
- Web Pages: Which Web Site?
- Other

Insurance Information

Please note that insurance does NOT cover the Contact Lens Evaluation

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
Yes / No

How will you settle your account today?
Cash / Check / Credit Card

Lifestyle Questions

Do you…(Check if yes)

- Work at a computer?
- Think you might benefit from thinner, lighter lenses?
- Spend time outdoors? How much?
- Have prescription sunwear?
- Prefer not to wear glasses at times?
- Have more than 1 pair of current prescription eyewear?
- Have children?
- Have family members in need of eye care?

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

- Blurry vision
- Cataracts
- Crossed eye/eye turn
- Eye infections
- Flashes of light
- Floaters
- Glaucoma
- Headaches