Horizon Eye Care Professionals

Exam Date ___________________________________

Patient Information

Last Name ___________________________________
First Name______________________MI __________
Preferred Name ______________________________
Street ______________________________________
City ____
State_____________________Zip Code___________
Date of Birth ________________________________
Primary Phone _______________________________
Other Phone _________________________________
Employer ____________________________________
Occupation (or Grade) _________________________
Email Address ________________________________
Parents (if a minor) ___________________________

What is the main reason for your visit today?
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Are you <u>currently</u> experiencing any of the following? Check all that apply.

- ❑ Blurry Vision *near or distance*
- ❑ Eyestrain/tired eyes
- ❑ Headaches
- ❑ Double Vision
- ❑ Trouble seeing at night
- ❑ Problems with Glare
- ❑ Sunlight sensitivity
- ❑ Excess tearing/watering
- ❑ Redness
- ❑ Itching
- ❑ Burning
- ❑ Dryness
- ❑ Sandy/Grittiness
- ❑ Uncomfortable glasses
- ❑ Other eye problems___________________________

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Our Mission

We will enhance your life by providing the best professional eye care services and products to improve and preserve your most precious gift, your vision.

Eye History

Date of Last Eye Exam (if Not Here) _______________
By Whom? ____________________________________

Do you wear glasses? ❑ Yes ❑ No
If yes, how old are they? ______________________
Do you currently wear contact lenses? ❑ Yes ❑ No
If yes, what kind?_______________________________
Solutions used? _________________________________
Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

If not wearing contact lenses:
Have you ever tried contact lenses? ❑ Yes ❑ No
Would you like to try contact lenses? ❑ Yes ❑ No

Have you experienced, or been treated for, any of the following? Check all that apply.

	Yes	**No**
Cataracts	❑	❑
Corneal Problems	❑	❑
Glaucoma	❑	❑
Crossed Eye	❑	❑
Lazy Eye	❑	❑
Macular Degeneration	❑	❑
Retinal Detachment	❑	❑
LASIK or PRK or RK	❑	❑
Blindness	❑	❑
Floating spots	❑	❑
Flashes of light	❑	❑
Loss of vision	❑	❑

Is there a family eye history of any of the following?
❑ Yes (Please check boxes) ❑ No

	Relationship to you
Blindness	❑ ______________________
Cataracts	❑ ______________________
Corneal Problems	❑ ______________________
Glaucoma	❑ ______________________
Crossed Eye	❑ ______________________
Lazy Eye	❑ ______________________
Macular Degeneration	❑ ______________________
Retinal Detachment	❑ ______________________

Do you have family members in need of eye care? ❑ Yes ❑ No
Were you referred to our office? ❑ Yes ❑ No
If yes, by whom? _____________________________
If not referred, how did you choose our office?
____

Please turn over and continue with the questions on the back

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

Medical History

Name of Family Physician_______________________
Town of Physician______________________________
Date of Last **Medical** Check-up___________________
CURRENT MEDICATIONS (Rx or Over the Counter)
(Bring list along or list names of medications including eye drops & vitamins, etc)___________________________
____
____
____
____
Medication Drug Allergies?______________________
____
Other Allergies?_______________________________
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Are you pregnant? ❑ or nursing? ❑
Do you smoke?_________________________________
Have you ever smoked? __________________________
Do you drink Alcohol?___________________________

Have you or a family member experienced , or been treated for, any of the following? Check all that apply.

	No	Self	Family
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
Heart Disease	❑	❑	❑
Stroke	❑	❑	❑
High Cholesterol	❑	❑	❑
Autoimmune Disorders	❑	❑	❑
Thyroid Dysfunction	❑	❑	❑
Gastrointestinal Conditions	❑	❑	❑
Kidney Disease	❑	❑	❑
Allergies	❑	❑	❑
Fibromyalgia	❑	❑	❑
Ears/Nose/Throat Conditions	❑	❑	❑
Blood Disorders	❑	❑	❑
Skin Conditions	❑	❑	❑
Arthritis	❑	❑	❑
Neurological Conditions	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
Depression	❑	❑	❑
Anxiety	❑	❑	❑
Asthma	❑	❑	❑
Sleep Apnea	❑	❑	❑
Cancer (type_____________)	❑	❑	❑

Please list any other conditions not listed above
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Lifestyle Questions

To help us learn your needs please answer the following questions.

Are you planning to purchase new glasses today?
❑ Yes ❑ No ❑ Maybe

Do you have a back-up or spare pair of glasses?
❑ Yes ❑ No ❑ Maybe

Do you wear sunglasses? ❑ Yes ❑ No

Do you use/need safety eyewear? ❑ Yes ❑ No ❑ Maybe

How many hours a day do you use a computer, tablet, or smart phone?___________________________

Are you interested in LASIK? ❑ Yes ❑ No ❑ Maybe

Are you interested in: (check all that apply)

Thinner lighter lenses	❑
Non-glare lenses	❑
Lenses that darken in the sun	❑
Rimless frames	❑
Polarized sun lenses	❑
No line (progressive) bifocals	❑

What are your interests or hobbies? (check all that apply)

hunting	❑	fishing	❑
sewing	❑	woodworking	❑
crafts	❑	aviation	❑
golf	❑	swimming	❑
skiing	❑	bicycling	❑
motorcycling	❑	computers	❑
reading	❑	video games	❑
sports	❑	television	❑

other ____

Copy of exam summary available upon request

Please use this space to explain or insert anything we may have missed or you feel is important. _______________
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_____________________________ ______________
Office use only, Doctor's Signature Date