WELCOME TO OUR OFFICE

Horizon Eye Care Professionals

Exam Date _____

Patient Information

Last Name _____
First Name _____ MI _____
Preferred Name _____
Street _____
City _____
State _____ Zip Code _____
Date of Birth _____ Age _____
Primary Phone _____
Other Phone _____
Employer _____
Occupation (or Grade) _____
Email Address _____
Parents (if a minor) _____

What is the main reason for your visit today?

_____
_____
_____
_____
_____
_____

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 _____

_____
_____

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.

Patient 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 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? Circle all that apply

Cataracts	Corneal Problems
Glaucoma	Macular Degeneration
Crossed Eyes	Lazy Eye/Amblyopia
Retinal Detachment	Blindness
Floating spots	Flashes of light
LASIK or PRK	any Refractive Surgery
Eye Allergies	Loss of Vision
None of the above	

Family Medical/Eye History

Is there a family history of any of the following?
Circle all that apply

	Relationship to you
Cataracts	_____
Corneal Problems	_____
Glaucoma	_____
Crossed Eyes	_____
Lazy Eye/Amblyopia	_____
Macular Degeneration	_____
Retinal Detachment	_____
Diabetes	_____
High Blood Pressure	_____
Heart Disease	_____
High Cholesterol	_____
Kidney Disease	_____
Rheumatoid Arthritis	_____
Lupus	_____
Multiple Sclerosis	_____

Other that you feel we should know about

_____

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.

Patient Medical History

Name of Family Physician_____
Town_____
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)_____

Do you have allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

Any other Allergies? _____

Are you pregnant? ❑ or nursing? ❑

Do you smoke? ❑ Yes ❑ No
Have you ever smoked? ❑ Yes ❑ No
How long ago?_____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Diabetes	❑	❑
High Blood Pressure	❑	❑
Heart Disease	❑	❑
Stroke	❑	❑
High Cholesterol	❑	❑
Thyroid Dysfunction	❑	❑
Rheumatoid Arthritis	❑	❑
Multiple Sclerosis	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Colitis	❑	❑
Anemia	❑	❑
Lupus	❑	❑
Depression	❑	❑
Anxiety	❑	❑
Allergies/Hay fever	❑	❑
Asthma	❑	❑
COPD	❑	❑
Sleep Apnea	❑	❑
Cancer (type_____)	❑	❑

Please list any other conditions not listed above
_____

Lifestyle Questions

Help us learn your needs

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

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

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

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	❑	golf	❑
bicycling	❑	motorcycling	❑
reading	❑	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. _____

_____ _____
Doctor's Signature Date