Welcome To Our Office

Horizon Eye Care Professionals

Exam Date _____

Last Name _____

First Name_____MI _____

Street _____

City _____

State _____Zip Code _____

Date of Birth _____Age _____

Primary Phone _____

Employer _____

Parents (if a minor) _____

Purpose of visit today?

Glasses ❑ Contacts ❑ Eye Health Check ❑

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
❑ Flashes or Floaters
❑ Other eye problems (list below)

_____

_____

_____

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 wear contact lenses? ❑ Yes ❑ No
If yes, what brand are they? _____
_____
How often do you replace them?_____

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

❑ Cataracts
❑ Glaucoma
❑ Crossed Eyes/Strabismus
❑ Lazy Eye/Amblyopia
❑ Floating spots
❑ Flashes of light
❑ Refractive Surgery
❑ LASIK or PRK
❑ Macular Degeneration
❑ Retinal Detachment
❑ Blindness
❑ Corneal Problems
❑ Eye Allergies
❑ Loss of Vision

Is there a family history of any of the following? (circle those that apply)

Relationship to you

Cataracts _____
Corneal Problems _____
Glaucoma _____
Crossed Eyes _____
Lazy Eye/Amblyopia _____
Macular Degeneration_____
Retinal Detachment _____
Vision Loss/Blindness _____

List any eye condition in your family history not listed above and how that person is related to you.

_____

_____

_____

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)
If you have a list, please provide us with a copy

_____

_____

_____

_____

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications?_____

_____

Any other Allergies? _____

_____

Are you pregnant? ❑ or nursing? ❑

Lifestyle Questions

Do you smoke? ❑ Yes ❑ No

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

How much time do you spend on an electronic device in a 24 hour period? _____

Please list any hobbies that you do on a routine basis

_____

_____

_____

_____

Patient Medical History

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 use this space to list current conditions not listed above or anything you feel is important

_____

_____

_____

_____

_____

_____

_____

_____

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.

Copy of exam summary available upon request